

QMRP MANUAL

A REFERENCE GUIDE
Prepared by Quality Support Team
Central Missouri Regional Center

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QMRP

INTRODUCTION

Qualified Mental Retardation Professional

Education and recommended experience and skills

This Manual was developed to be used as a resource for the Qualified Mental Retardation Professional (QMRP). The roles and responsibilities are defined with examples of monitoring tools that can be used with some of these duties. Some of the duties as described in this manual may actually fall into the role of the administrator; it is at their discretion that the roles are defined. By using this manual, the QMRP will be able to deliver a consistent service for the provider and consumers.

The QMRP is at the center of all discussion with family, consumer, staff, administration and Regional Center. The QMRP serves as a liaison among all disciplines. Communication skills, problem solving skills, and leadership skills are crucial for this employee. The QMRP must possess knowledge of the community for area resources, and feel comfortable in developing partnerships with other organizations and agencies.

The QMRP will address concerns voiced by family, consumers, staff members, administration, and service coordinators. There may be times when all of these disciplines will meet to discuss issues or situations of concern.

Required education, experience, and skills:

- Completion of a Bachelors Degree in a Human Services field, including but *not* limited to: sociology, special education, rehabilitation, nursing, counseling, and psychology. (refer to Medicaid Waiver Manual)
- At least one year experience working directly with individuals with mental retardation or developmental disability.
- Must attend the following training: Behavior Support Training, such as CPI or MANDT; Abuse and Neglect Training; CPR and First Aid Training; and hold certification in Level One Medication Aide Training.

It is understood that all providers are different and that the QMRP may not be completing all the duties stated in this reference manual from beginning to end. In a small agency, the owner may be performing some of the duties that are listed as QMRP duties in this manual. In a larger agency, there may be more shared duties with middle management staff. HOWEVER, it is the responsibility of the provider agency to be sure the assigned QMRP has knowledge and significant input into the numerous duties listed in this manual. It is the expectation that the QMRP is central to the decision making aspects of consumer supports.

DEFINITIONS

Addendum-a written change to the personal plan

Autism- a developmental disability typically appearing during the first three years of life with symptoms of self-absorption, inaccessibility, and inability to relate due to impaired communication skills.

Behavior Support Plan (BSP)- A plan written by the team to focus on assisting the consumer to overcome challenging behaviors. This plan will include step by step instructions for staff to follow for consistency in providing the supports the consumer needs to remain safe. The BSP is included in the Person Centered Plan.

Crisis Intervention Team- A team of qualified technicians trained to work with consumers with personal, social, and/or behavioral problems which otherwise may be threatening to the health and safety of themselves or individuals within their environment.

Choice Statement - The consumer is given the opportunity to choose the provider of their choice. There is a form that is signed indicating this choice.

Community Event Report (CER) - A form used to document incidents that occur to individuals receiving services funded through DMH.(Department of Mental Health)

Community Integration- is a service in which a consumer is assisted in becoming an active participant in his or her community.

Daily Progress Notes- is Medicaid Waiver required; consumer specific; and written documentation of the day's events used to convey information to other staff and to complete monthly reviews.

DMH 57- is a contract agreement with a provider outlining the categories of funding for a consumer in placement in a Department of Health facility.

First Steps-a collaborated program between Department of Mental Health, Social Services, Health and Elementary and Secondary Education. It offers a program consistent of planning, developing and implementing a network of family-focused services for consumers from 0-3 years of age.

FLA- Family Living Arrangement, this is a residential facility, under licensure, serving no

more than 3 residents who are integrated into the licensee's family unit.

Group Home - a residential facility serving 9 or fewer residents providing basic health supervision; habilitation training in skills of daily and independent living; community integration; and social support.

HIPPA-Health Insurance Portability and Accountability Act of which all staff must be trained on information security practices.

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ICF-MR (Intermediate Care Facility-Mental Retardation)- To indicate eligibility for Medicaid Waiver Program, an ICF-MR Level of Care form is completed and submitted.

IEP- Individualized Education Plan written by the treatment team in the school setting. It details a student's educational program and particular needs related to their education.

IFSP-Individual Family Service Plan, this is a written plan for children enrolled in the First Steps program.

ISL-Individual Supported Living, is a non-facility based form of residential habilitation which provides support and training in the individuals own residence. Individuals may live alone or with their families, if the living arrangements are shared, no more than 3 individuals with disabilities may reside together to qualify for ISL services.

Medicaid Waiver-a funding source in which 40% of the cost of services comes from other funding sources and the Federal Government pays 60%. These are services not typically covered by Medicaid alone.

Missouri Quality Outcomes- ensure opportunities for quality of life. They reflect best practice, and provide us with a look at outcomes that define a typical lifestyle desired by anyone.

MOCABI-Missouri Critical Adaptive Behaviors Inventory is a tool used to assess the functional capabilities of an adult consumer to help determine eligibility for services and the level of supports needed.

MRDD-Mental Retardation and Developmental Disabilities, this is a branch of the

Department of Mental Health which serves persons with mental retardation or developmental disabilities. The person must meet specific criteria for eligibility for services. The developmental disability must have occurred before the age of 22 and this person has substantial limited ability to function independently.

NAFs Account-Non-Appropriated Funds, an account which holds the consumer's benefit monies when the Regional Center is the payee or the consumer is considered to be in community placement. The benefit amount of this account is used towards room, board, and personal spending each month. When there are excess funds in the account, the money can be used to recover the cost of care, or can be approved to be used for other spending.

Monthly Review- is a Medicaid Waiver required monthly summary of the consumers progress and other pertinent information, such as community outings, medical issues, and family contact.

Person Centered Plan (PSP) - a written document describing the functional level of the consumer, the consumers dreams and wishes, the goals for the upcoming year, and an action plan with how to accomplish, who is responsible for what, and where the funding sources are coming from. This plan is also referred to as the Individual Plan or Personal Plan.

Personal Spending-the amount of money set aside from the consumer's benefit check to be used for minor purchases, it is typically \$30/month.

POS-Purchase of Service is a funding source through which paper work is completed and a service is purchased for a consumer.

Quality Management Plan-a written document for the intent of correcting a situation or spelling out how an improvement can be made in identified areas.

Quality Management Team - the team designed to assist case managers, consumers, and providers in quality assurance issues. The team consists of RN's, Crisis Intervention persons, and Training Team members.

QMRP-qualified mental retardation professional, hired to provide oversight and to ensure services are being delivered and consumers rights are being respected.

Lopez Waiver-a children's waiver for funding assistance to qualified individuals and their

families. It allows certain State Medicaid eligibility requirements to be waived so children targeted for participation may be determined eligible for Medicaid. To qualify parents must have insurance and submit billing to that insurance first, then to Medicaid.

B40 Board (Senate Bill 40)- a county tax board which administers funds for services to people with mental retardation or developmental disabilities in their community.

SB40 Match-a funding source in which the SB40 Board will match a specified amount of money with the Regional Center for a specific waived service.

Semi-Independent Living Arrangement - a community residential facility composed of individual living units or apartments having a bedroom space, living space, and a kitchen for up to 3 residents. Protective oversight is provided by staff living on site or in close proximity, normally in the same building.

Service Agreement-a document that explains how the Regional Center functions, it is to be reviewed and signed by all new consumers. This is a part of the initial application process.

Service Monitoring-this is part of service coordination, it is a means to monitor consumer health, environmental issues, personal safety, rights, services, and finances of the consumer.

Shared Unit Agreement-a funding source in which the provider and the Regional Center each agree to put in a certain amount of money for specified services.

Staffing Patterns - are determined by the Regional Center during a contract process.

It is an outline of the ratio of staff to consumer in an ISL, Residential Habilitation, and Day Habilitation for each hour, every day of the week, according to consumer numbers. If there is a change needed in the number of hours, then approval must be made prior to the change.

Standard Means Test-is a process that determines a consumer/family's income and the ability of the family to contribute a payment for some of the services provided. State statutes require that the Standard Means test be completed annually.

Support Agreement-is a signed contract between a family and Department of Mental Health-Mental Retardation and Developmental Disabilities, included with the Personal Plan.

Title IV-A-is a funding source through the Children's Division for consumers 18 years of age or younger.

Training Plan- is a plan outlining the process for completing an Action Step or outcome of the Personal Plan.

Vineland-is an instrument used to assess the functional capabilities of someone younger than 18 years old. It is completed by the service coordinator to help determine eligibility and the level of supports needed.



Website Information

www.mo.gov

Code of State Regulations (CSR's)

www.networkofcare.com

Network of Care

www.dmh.missouri.gov

Department Operating Regulations (D.O.R.)

www.moga.state.mo.us

Missouri Revised Statutes (RSMO)

www.dhhs.gov

Facility Operating Regulation (F.O.R.)

<http://dmh.mo.gov/CMRC>

Central Missouri Regional Center

<http://www.dmh.mo.gov/mrdd/nurses/rnhome.htm>

MRDD Quality Management Nursing Webpage

<http://cms.hhs.gov/maunuals/pub07pdf/pub07pdf.asp>

HCFA State Operation Manual for Medicaid- Section J for MR care facility (Section PP for state LTC facility)



QMRP

RESPONSIBILITIES

CONSUMER RELATED FUNCTIONS

1. Active participation in the person centered planning process
 - Attend the individual planning meeting
 - Provide input in the individual planning
 - Coordinate the development of individual training plans
 - Ensure all necessary documentation is in place
 - Review progress notes and daily notes
 - Monitor for the implementation of the person centered plan
 - Summarize significant data into monthly review documentation
 - Sign all monthly reviews
 - Communicate with service coordinator about your findings with data collection, observations, and feedback from staff
 - Participate in the completion of the quality management plan
2. Coordination and oversight of Medical Appointments
 - Provide assistance if needed for the scheduling of appointments
 - Coordinate the transportation with staff for appointments
 - Ensure all follow up appointments are scheduled and kept
 - Review documentation of the consult forms
 - Monitor for implementation of orders or recommendations
 - Summarize significant data into the monthly review
3. Face to face visits with each consumer
 - Actively participate in personal plan objectives
 - Ensure that consumer rights are being respected
 - Work with the consumer to share concerns, wants, wishes, and assist in resolving issues as needed.
 - Facilitate opportunities for natural supports in the community
 - Advocate for consumer choice
4. Monitor for consumer safety
 - Review community event report, complete the action steps to prevent reoccurrence, submit to Regional Center, and follow up with staff involved.
 - Ensure that Fire Safety and Tornado drills are being completed
 - Ensure that the physical environment of the consumer is safe
 - Ensure all vehicles used to transport consumers are safe
 - Ensure that water temperature is at a safe level.
 - Ensure that staff members transporting consumers have an active driver's license.

CONSUMER RECORD RELATED FUNCTIONS

The QMRP will provide coordination and oversight of maintaining current data in consumer record. This data will include:

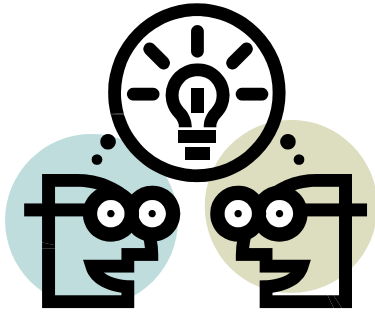
- Consumer profile data with emergency contact numbers
- Copies of the Medicaid/Medicare cards, current Release of Information forms, Consent forms, Choice Statements, and signed Client rights statement.
- Copies of guardianship paperwork
- Financial records to include documentation supporting NAF's account spending; personal spending; and petty cash spending
- Daily progress notes, monthly reviews and other consumer related documentation as referred to in *consumer related functions*
- Medical Information to include documentation of:
 - Annual physical, dental, and PPD screening; vision screening as recommendation of the screening physician, lab results, Hepatitis B screening, immunizations; and diagnosis for all medications prescribed.
- Monthly Health Summary of the Community Registered Nurse
- Physician orders for adaptive equipment and documentation of maintenance and upkeep of the adaptive equipment.

QUALITY ASSURANCE RELATED FUNCTIONS

1. Maintain confidentiality of all consumers Protected Health Information use for treatment, payment, health care, etc. as set up by the Health Insurance Portability Accountability Act of 1996. (HIPPA)
2. Maintain a log of QMRP hours worked per consumer
3. Review all Community Event Reports, notify Regional Center, and provide oversight for the follow up plan with staff
4. Maintain communication with family members, guardians, staff and Regional Center about policies, issues, or concerns.
5. Prepare and submit reports that are required by law or regulation.

STAFF RELATED FUNCTIONS

1. Provide supervision over direct care staff for implementation of the individual plan
2. Provide training to direct care staff for strategies of implementation of the individual plan
3. Provide support strategies for development of behavior support plans, when needed.
4. Coordinate in service trainings needed to assist staff in fulfilling responsibilities related to consumer directed support.
5. Provide oversight with documentation of the medication administration record.
6. Maintain record keeping of all required trainings for staff and schedule updates as needed to remain current with the trainings.
7. Provide direct support in providing services needed to protect the health and safety of the consumer, in a staffing crisis.
8. Provide training and oversight for staff about: Medicaid Waiver guidelines; licensing regulations, as they relate; CARF principles as they relate; and certification standards, as they relate.
9. Communicate with the Community RN about concerns and findings
10. Coordinate and assist the staff with maintaining positive relationships with funding agencies.
11. Be available to respond to staff in case of an emergency.



QMRP

STRATEGIES

HOW TO "B" SUCCESSFUL

Be strong in your understanding of the MRDD Certification Guidelines

Be a self advocate in your role with the Agency and Regional Center

Be a role model in implementing the person centered plans in a timely fashion

Be knowledgeable in consumer support needs and advocate for them

Be eager to teach and train the direct care staff in what they need

Be open to suggestions and comments from team members

Be organized and use time management skills

Be proactive in approaches with consumers, family members, staff members, agency, and community contacts

Be approachable and use communication skills

Be willing to delegate tasks when needed and follow up to ensure completion

Be alert in reviewing reports, documentation of implementation of the plans

Be diligent in attending trainings to enhance your knowledge about QMRP responsibilities, consumer needs, and staff training needs.

TIME SENSITIVITY

BACKGROUND CHECKS - must be completed on all employees prior to contact with consumers. The Family Care Registry is a preferred mechanism.

BUDGETS: due by the 15th of each month prior to the plan implementation (or service implementation)

COMMUNITY EVENT REPORTS: CER requires immediate notification to Regional Center after consumer needs are addressed. If event occurs after 5pm or on weekends, the on call person can be contacted. The report must be completed and forwarded within 24 hours.

DETECTORS (Smoke/Fire/Carbon Monoxide): Batteries should be changed twice per year with documentation.

EMERGENCY DRILLS: Fire drills are to be completed and documented on a quarterly basis (time of day should vary); Tornado drills are to be completed and documented on an annual basis. Drills should be conducted within one week of a new consumer moving into placement.

FIRE EXTINGUISHERS: Need to be checked and initialed per recommendation of company. Group Homes must have a fire safety inspection annually by State Fire Marshall or local fire authority>

MEDICAL ISSUES: Annual requirements: physical exam, dental exam, tuberculosis screening. Vision requirements vary in accordance to recommendations made at previous appointment.

MONTHLY REVIEW: submitted to the Regional Center by the 15th of each month. A scheduled time agreeable by both the QMRP and the service coordinator must be made to discuss consumer progress and issues.

NAFS REQUEST: The QMRP coordinates with the service coordinator to access funds from NAFs account (or purchases over \$100). The request must occur prior to the purchase of an item and is to be used within 90 days of approval.

PFFR QUARTERLY REPORTS: Due quarterly by January 31st, April 30th, July 31st, and October 31st each year.

PLANS: Meeting dates to revise and update an Individual Person Centered Plan typically occur 60-90 days prior to implementation date. The provider should have the signed copy of the new plan with any approvals needed prior to the implementation date.

PROVIDER TRAINING RECORD: These are kept in provider files; however any new employee who has required training to complete must have evidence of this training prior to consumer contact.

QMRP LOGS: This is record of hours worked per consumer. A copy of the log may need to be available for review.

RIGHTS: Client rights must be reviewed with consumer and/or guardian on an annual basis with signatures.

WHEN TO CONTACT THE SERVICE COORDINATOR

Here are some common examples of **WHEN** to contact the service coordinator:

- When there is a hospitalization, a change in residence, placement status, or funding needs
- When there are changes in services, regardless of whether there is a need to increase, decrease, or make additions
- When there is a request for new services or new placement by a consumer
- When any major change in status: medical or behavior, and when a community event report is completed.
- When referrals are made to other state or community agencies
- When there is a change in benefits or benefit status
- When a consumer, family member, or provider has a complaint that can not be resolved
- When changes need to be made in the person centered plan, the outcomes, or the action steps
- When you have any doubts, contact the service coordinator!



QMRP

CONSUMER RECORDS

CONSUMER NOTEBOOK SETUP

Agencies will want to maintain a notebook for the regular consumer file and a Medication Administration and Treatment notebook.

CONSUMER FILE:

A. EMERGENCY INFORMATION

1. BOLD ALERT FOR ANY ALLERGIES
2. Photograph/Consumer Profile Data Sheet
3. Emergency Contact Information
4. Medicaid /Medicare Information (usually maintained in small zipper bag)
5. Consent forms

B. ADMISSION INFORMATION

1. Review of Client Rights
2. Referral and Consent for Admission
3. Guardianship papers and information
4. Client Choice of Provider for services statement

C. PERSONAL PLAN INFORMATION

1. Copy of personal plan with authorization page signed and dated.
2. Training plans and data collection forms for the IP year
3. Signed addendums, if applicable
4. IP Monthly review
5. Community RN Health Summary

D. PROGRESS NOTES

1. Daily documentation of consumer life experiences
2. Documentation on data sheets as related to the objectives
3. Monthly Review

E. MEDICAL INFORMATION

1. ANNUALS

- Annual physical
- Annual tuberculin exam
- Annual dental
- Vision Screening, the latest screen with recommendation for follow up

2. LABS

3. IMMUNIZATIONS (to include Hepatitis B information)
4. CONSULTATIONS (other specialists or Physician visits)

5. MONITORING , this would include vital signs, weights, seizure reports, etc.

F. ASSESSMENTS

1. Behavioral assessments
2. School assessments
3. Judevine assessments
4. Therapy assessments, etc.

G. CORRESPONDENCE

1. Letters from/to guardians
2. Letters from/to school or day program
3. Any other correspondence the agency has identified to keep.

H. BUDGET-if ISL placement

MEDICATION ADMINISTRATION Notebook

(In keeping a separate notebook, the availability for documentation and accountability for treatments completed is greater)

1. Current Physician orders or prescriptions
2. Update listing of diagnosis and medication allergies (if any)
2. Medication Administration Record sheets, referred to as the MAR
3. Information about side effects for current medications
4. Physician ordered treatment sheets

INFORMATION IN CONSUMER RECORDS

Documentation Requirements and Location:

Individual Rights Brochure and 9CSR 45.3.030, states that all people have the right to have access to their personal records and to have those records maintained confidentially.

Medicaid Waiver Program Manual under 13.9 Adequate Documentation; states that all documentation must be made available at the same site at which the service was rendered, with the exception of in home services such as personal care and home health. Section 13.3 state that Records must be maintained for 6 years on the consumers, and the Community Event Reports, forever.

Documentation Recommendations:

Keep information from the current past year in the consumer file. This will enable the provider to keep annual visits current, and follow up visits scheduled in a timely manner. Examples for what needs to be in the current record include:

- Consumer information page with contact numbers
- Current Personal Plan with Consumer/Guardian signatures of Approval
- Rights Reviews
- Due Process's and documentation of progress
- Service Coordinators Monthly/Quarterly reports
- Provider Monthly reports
- Community RN Monthly Health Summaries
- Health Inventory and Action Plan, where indicated.
- Physician Orders for medications, diet, adaptive equipment
- Annual visits: physical, dental, vision as indicated
- Consult visit forms of specialists or other visits

The following information should never be purged from the individual's home record:

- Immunizations records including Hepatitis B, pneumonia and flu vaccination
- Evaluations/reports to communicate pertinent information, such as placement of medical devices, (shunt, pacemaker), and positive test results with record of treatment (known tuberculosis reactor and/or history of infectious disease)
- Any personal history that is not in the current personal plan that may help caregivers in knowing what supports are needed
- Any known allergies or adverse reactions to medications
- Emergency information with updates as needed
- Guardianship information with updates as needed

MRDD Medicaid Waiver Requirements

13.16 Individualized Supported Living (Comprehensive Waiver Only) Residential Habilitation Service Documentation

Implementation of services **must** be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation. The provider is required to document the provision of MRDD Waiver services by maintaining:

- Attendance or census records documenting days of service signed by the provider or designated staff.
- Daily activity records that describe various covered activities (services) in which each person participated;
- Records of which staff provided each unit of service;
- Documentation that each staff is qualified to provide the service;
- Progress notes by direct care staff regarding situations or incidents (good or bad) that arise affecting the individual;
- Monthly summaries that describe progress on the individual's person centered plan goals and objectives and overall status of the individual; and
- A written annual assessment addressing progress and specific recommendations for service in conjunction with the individual's Personal Plan review.

13.17.H Individualized Supported Living Service Documentation

Implementation of services **must** be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive individualized supported living and at least quarterly for individuals who live in their natural home. The provider is required to document the provision of MRDD Waiver services by maintaining:

- Attendance or census records documenting days of service signed by the provider or designated staff.
- Daily activity records that describe various covered activities (services) in which each person participated;
- Records of which staff provided each unit of service;
- Documentation that each staff is qualified to provide the service;
- Progress notes by direct care staff regarding situations or incidents (good or bad) that arise affecting the individual;
- Monthly summaries that describe progress on the individual's person centered plan goals and objectives and overall status of the individual; and
- A written annual assessment addressing progress and specific recommendations for service in conjunction with the individual's Personal Plan review.

13.9 ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (1)(A) defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered, with the exception of in-home services such as personal care, home health, etc.

For MRDD providers, reference to "medical records" should be equated to individual records the provider maintains that include the person's plan of care, progress notes, medical information, dates of service, units of service provided, type of service provided and person providing the service.

13.9.A DOCUMENTATION

Implementation of services *must* be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized supported living and at least quarterly for individuals who live in their natural home. The provider is required to document the provision of MRDD Waiver services by maintaining:

- attendance or census records documenting days of service signed by the provider or designated staff;
- daily activity records that describe various covered activities (services) in which each person participated; records of which staff provided each unit of service; documentation that each such staff is qualified to provide the service;
- progress notes by direct care staff regarding situations or incidents (good or bad) that arise affecting the individual;
- monthly summaries that describe progress on the individual's person centered plan goals and objectives and overall status of the individual; and
- a written annual assessment addressing progress and specific recommendations for service in conjunction with the individual's Personal Plan review.

All providers must follow the above documentation requirements unless otherwise noted under specific MRDD Waiver services in Sections 13.16 through 13.33. Any additional requirements for a specific service are also included in these sections.



CONSUMER RIGHTS

CONSTITUTIONAL RIGHTS

Every individual receiving services from CMRC has the same Constitutional Rights as anyone else, Unless those rights have been abridged through legal documentation. If the person is unable to read or unable to understand the written description of their rights, a delegate will read the rights and assist them in understanding. **CMRC requires annual review with signature from the consumer and guardian**

We believe that individuals have a right:

- To be treated with respect and dignity as a human being
- To have these legal rights unless otherwise limited by law
- To receive appropriate humane and high quality services and supports as determined by person's support team
- To receive services regardless of gender, race, Creed, Marital status, national origin, disability or age
- To receive services and supports in the most integrated setting and in a way that best meets the needs of that individual.

We believe that individuals have a right for:

- Information regarding their rights
- Free speech and expression
- Freedom of religion
- Vote, unless otherwise limited by law
- Contact, own, and sell property
- Management of personal monies
- Freedom of participation
- To marry and have children

We believe that individuals have a right to be involved in any decisions made about having their rights restricted.

- Equal protection under the law & Due Process
- Fair Access to courts and legal representation
- Exercise of Individual Rights

We believe that individuals are free to communicate privately

- Right to privacy
- use of the telephone
- Freedom of Association

We require that all staff be trained in preventing, detecting, and reporting abuse/neglect.

EXAMPLES OF RIGHTS RESTRICTIONS*

- 1) Limiting Cigarettes**
- 2) Limiting Food or Fluid Intake**
- 3) Alarms on doors**
- 4) Privacy issues such as:**
 - a. bedroom door kept open**
 - b. no males/females in bedroom**
 - c. phone calls in front of staff**
- 5) Gates used in home**
- 6) Locks on fences**
- 7) Locks on refrigerators**
- 8) Locked kitchen**
- 9) Areas off limits in home**
- 10) Lap belts, bedrails**
- 11) Limiting any type of property (radios, phone, etc.)**
- 12) Loss of activity due to behavior**
- 13) Restitution**
- 14) No food/drink in room**
- 15) Limiting use of phone**
- 16) Control own money**
- 17) Restrict from self administration of meds if they are able**
- 18) Leaving home, being alone in community**
- 19) Limiting who they are able to socialize with**
- 20) Limiting opportunity to learn**
- 21) Making certain the person finishes everything on their plate**
- 22) Making someone go to bed a certain time or making them stay awake**

***will need to be looked at with the team and reviewed by the Human Rights committee**

Due Process

(as extracted from the Due Process brochure for consumers)

- When you apply for services, the regional center or habilitation center must give you, your parents, your guardian, or any other person you choose a written copy of your rights. If any changes in your services are made, you will receive a new copy of your rights.
- Regional centers, habilitation centers and provider agencies that have staff who work with you have rules to provide you good help. They have rules to make sure you learn and understand your rights, and that no one takes your rights away before you have a chance to speak for yourself or have someone you choose speak for you. This is called due process.
- Someone from the regional center or habilitation center will read and explain your rights to you in a way you understand them.
- You have the same legal rights and responsibilities as any other person unless the court says you do not. For example, if you have a guardian, you do not have the same legal rights as people without a guardian.
- You have the right to be treated with respect and dignity as a human being.
- You have the right to get help. You cannot be denied help because of your race, your religion, your disability or your age. It does not matter if you are a man or woman, married or single.
- Before your rights or service can be limited or taken away, you have the right to be heard or to have someone you choose speak for you. This is called due process.

STATE of MISSOURI
DEPARTMENT of MENTAL HEALTH
CENTRAL MISSOURI REGIONAL CENTER
“FOR”

F.O.R. #

4.003

DIRECTOR

CHAPTER SUPPORT	SUBCHAPTER Committees	EFFECTIVE DATE 5-15-87	NO. Of PAGES 2	PAGE NUMBER 1
SUBJECT Human Rights Committee		AUTHORITY 630.135 RSMo	HISTORY Revised 5-3-05 Revised 2-1-05 Revised 9-18-87	

PURPOSE: Prescribes the establishment of a facility Human Rights Committee.

APPLICATION: Applies to the Central Missouri Regional Center (CMRC)

- (1) A Human Rights Committee shall be established to assure the civil rights of Central Missouri Regional Center consumers.
- (2) The Committee shall be appointed by the Center Director and may be composed of at least the following individuals:
 - A consumer representative
 - MOAIDD representative
 - Regional Program Specialist, or their designee
 - Quality Support Team members, as assigned
 - Casemanagement Supervisor, as assigned
 - Service Coordinator/Casemanager, as assigned
 - Central Missouri Regional Center Abuse/Neglect Investigator
- (3) Non-DMH (Department of Mental Health) Committee members will be appointed to rotating terms to insure continued experienced representation. Training as to the responsibilities and duties of Committee membership will be provided.
- (4) The Service Coordinator/Casemanager, or their designee, who authored a behavior support plan being reviewed by the Human Rights Committee will be expected to participate in the meeting process to answer questions and provide insight for the Committee. Any applicable CMRC staff member providing quality support to the agency involved with the consumer should also attend the Committee’s review of the plan.

- (5) A provider agency representative supporting a consumer whose plan is being reviewed by the Human Rights Committee may participate in the Committee's review process
- (6) The Central Missouri Regional Center's Human Rights Committee shall be responsible for:
- Reviewing plans in which a consumer's right(s) are being proposed for restriction to assure that a limitation does not occur without a due process review.
 - Review behavior support plans incorporating physical, chemical, or mechanical restraint prior to implementation.
 - Review behavior support plans proposing a time-out intervention prior to implementation.
- (7) There must be a minimum of four members present to conduct a meeting.
- (8) A "Due Process Review" disposition will be completed by the Human Rights Committee Chairperson and forwarded to the consumer's Service Coordinator/Casemanager and their Casemanagement Supervisor. The Service Coordinator/Casemanager will then disseminate this document to the provider supporting the consumer and any applicable Central Missouri Regional Center Quality Support Team.
- (9) Member involved with the agency. Any behavior support plan and "Due Process Review" addressing a physical, chemical, or mechanical restraint as well as a time-out intervention will be forwarded to the Behavior Support Committee Chairperson by the Human Rights Committee Chairperson for a second review. A copy of all "Due Process Reviews" will be maintained by the Human Rights Committee Chairperson.
- (10) Any Human Rights Committee member who has been directly involved in the development of a behavior support plan being reviewed by the Committee is excluded from decision-making relative to that plan.

**Title 9--DEPARTMENT OF MENTAL HEALTH
Division 10--Director, Department of
Chapter 5--General Program Procedures**

9 CSR 10-5.200 Report of Complaints of Abuse, Neglect and Misuse of Funds/Property.

PURPOSE: This rule prescribes procedures for reporting and investigating complaints of abuse, neglect and misuse of funds/property in a residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health (department) as required by sections 630.135, 630.167, 630.168, 630.655 and 630.710, RSMo. The rule also sets forth due process procedures for persons who have been accused of abuse, neglect and misuse of funds/property.

(1) The following words and terms, as used in this rule, mean:

(A) Class I neglect, failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result;

(B) Class II neglect, failure of an employee to provide reasonable or necessary services to a consumer according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior which may cause psychological harm to a consumer due to intimidating, causing fear or otherwise creating undue anxiety;

(C) Consumer, individual (client, resident, patient) receiving services directly from any program or facility contracted, licensed, certified or funded by the department;

(D) Medications

1. "Medication Error", a mistake in prescribing, dispensing, or administering medications. A medication error occurs if a consumer receives an incorrect drug, drug dose, dosage form, quantity, route, concentration, or rate of administration. This includes failing to administer the drug or administering the drug on an incorrect schedule. Levels of medication errors are:

A. "Minimal", medication error is one in which the consumer experiences no or minimal adverse consequences and receives no treatment or intervention other than monitoring or observation is required;

B. "Moderate", medication error is one in which the consumer experiences short-term reversible adverse consequences and receives treatment and or intervention in addition to monitoring or observation; and

C. "Serious", medication error is one in which the consumer experiences life-threatening and/or permanent adverse consequences or results in hospitalization or an emergency room episode of care.

2. "Serious" medication errors may be considered abuse or neglect and shall be subject to investigation by the Department of Mental Health.

(E) Misuse of funds/property, the misappropriation or conversion for any purpose of a consumer's funds or property by an employee or employees with or without the consent of the consumer;

(F) Physical abuse—

1. An employee purposefully beating, striking, wounding or injuring any consumer; or
2. In any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner. Physical abuse includes handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management;

(G) Sexual abuse, any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. This includes but is not limited to:

1. Kissing;
2. Touching of the genitals, buttocks or breasts;
3. Causing a consumer to touch the employee for sexual purposes;
4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation;
5. Failing to intervene or attempt to stop, or encouraging inappropriate sexual activity or performance between consumers; and

(H) Verbal abuse, an employee using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner to a consumer or about a consumer in the presence of a consumer.

(2) This section applies to any director, supervisor or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the Department of Mental Health. Facilities, programs and services that are operated by the department are regulated by the department's operating regulations and are not included in this definition.

(A) Any such person shall immediately file a written or verbal complaint if that person has reasonable cause to believe that a consumer has been subjected to any of the following misconducts while under the care of a residential facility, day program or specialized service:

1. Physical abuse;
2. Sexual abuse;
3. Misuse of funds/property;
4. Class I neglect;
5. Class II neglect;
6. Verbal abuse;
7. Serious medication error; or
8. Diversion of medication from intended use by the consumer for whom it was prescribed.

(B) A complaint under subsection (A) above shall be made to the head of the facility, day program or specialized service, and to the department's regional center, supported community living placement office or district administrator office.

(C) The head of the facility, day program or specialized service shall forward the complaint to—

1. The Children's Division if the alleged victim is under the age of eighteen (18); or
2. The Division of Senior Services and Regulation if the alleged victim is a resident or client of a facility licensed by the Division of Senior Services and Regulation or receiving services from an entity under contract with the Division of Senior Services and Regulation.

(D) Failure to report shall be cause for disciplinary action, criminal prosecution, or both.

(3) The head of the facility, day program or specialized service that is licensed, certified or funded by the department shall immediately report to the local law enforcement official any alleged or suspected—

(A) Sexual abuse; or

(B) Abuse or neglect which results in physical injury; or

(C) Abuse, neglect or misuse of funds/property which may result in a criminal charge.

(4) If a complaint has been made under this rule, the head of the facility or program and all employees of the facility, program or service shall fully cooperate with law enforcement authorities and with department employees or employees from other agencies authorized to investigate the complaint. Failure to cooperate may result in contract termination or dismissal of the employee.

(5) A department investigator shall gather facts and conduct an investigation regarding the alleged abuse or neglect. The investigation shall be conducted in accordance with the procedures and time frames established under the department's operating regulations. Upon completion of the investigation, the investigator shall present written findings of facts to the head of the supervising facility.

(6) Within ten (10) working days of receiving the final report from the investigator, if there is a preliminary determination of abuse, neglect or misuse of funds/property, the head of the supervising facility or department designee shall send to the alleged perpetrator a summary of the allegations and findings which are the basis for the alleged abuse/neglect/misuse of funds or property; the provider will be copied. The summary shall comply with the constraints regarding confidentiality contained in section 630.167, RSMo and shall be sent by regular and certified mail.

(A) The alleged perpetrator may meet with the head of the supervising facility or department designee, submit comments or present evidence; the provider may be present and present comments or evidence in support of the alleged perpetrator. If the alleged perpetrator wishes to have this meeting, s/he must notify the head of the supervising facility or department designee within ten (10) working days of receiving the summary.

(B) This meeting shall take place within ten (10) working days of notification, unless the parties mutually agree upon an extension.

(C) Within ten (10) working days of the meeting, or if no request for a meeting is received within ten (10) working days of the alleged perpetrator's receipt of the summary, the head of the supervising facility or department designee shall make a final determination as to whether abuse/neglect/misuse of funds or property took place. The perpetrator shall be notified of this decision by regular and certified mail; the provider will be copied. If the charges do not meet the criteria in paragraphs (11) & (12), the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(D) If the charges meet the criteria in paragraphs (11) & (12), the letter shall advise the perpetrator that they have ten (10) working days following receipt of the letter to contact the department's hearings administrator if they wish to appeal a finding of abuse, neglect or misuse of funds/property.

(E) If there is no appeal, the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(F) The department's effort to notify the alleged perpetrator at his/her last known address by regular and certified mail shall serve as proper notice. The alleged perpetrator's refusal to receive certified mail does not limit the department's ability to make a final determination. Evidence of the alleged perpetrator's refusal to receive certified mail shall be sufficient notice of the department's determination.

(7) If an appeal is requested, the hearings administrator shall schedule the hearing to take place within thirty (30) working days of the request, but may delay the hearing for good cause shown. At the hearing, the head of the supervising facility or designee, or other department designee shall present evidence supporting its findings of abuse, neglect, misuse of funds/property, or all. The provider or perpetrator may submit comments or present evidence to show why the decision of the head of the supervising facility or department designee should be modified or overruled. The hearings administrator may obtain additional information from department employees as s/he deems necessary.

(8) The decision of the hearings administrator shall be the final decision of the department. The hearings administrator shall notify the perpetrator, and the head of the supervising facility or department designee by certified mail of the decision within fourteen (14) working days of the appeal hearing; the provider will be copied.

(9) The opportunities described in sections (6), (7) and (8) of this rule regarding a meeting with the head of the supervising facility and an appeal before the department's hearings administrator apply also to providers and alleged perpetrators in an investigation of misuse of funds/property.

(10) For those charges in paragraphs (11) & (12), an alleged perpetrator does not forfeit his/her right to an appeal with the department's hearings administrator when s/he declines to meet with the head of the supervising facility under subsections (6)(A) and (B) of this rule.

(11) If the department substantiates that a person has perpetrated physical abuse, sexual abuse, class I neglect, or misuse of funds/property, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo. Persons who have been disqualified from employment may request an exception by using the procedures described in 9 CSR 10-5.210 Exception Committee Procedures.

(12) If the department substantiates that a person has perpetrated two (2) counts of verbal abuse, or two (2) counts of class II neglect, or one (1) count of verbal abuse and one (1) count of class II neglect, within a twelve (12)-month period, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo.

(13) In accordance with 9 CSR 10-5.190, no person convicted of specified crimes may serve in facilities or programs licensed, certified or funded by the department.

(14) No director, supervisor or employee of a residential facility, day program or specialized service shall evict, harass, dismiss or retaliate against a consumer or employee because he or she or any member of his or her family has made a report of any violation or suspected violation of consumer abuse, neglect or misuse of funds/property. Penalties for retaliation may be imposed up to and including cancellation of agency contracts and/or dismissal of such person.

AUTHORITY: sections 630.050, 630.135, 630.165, 630.167, 630.168, 630.655 and 630.705, RSMo 2000 and 630.170, RSMo Supp. 2003. Original rule filed Oct. 29, 1998, effective May 30, 1999. Emergency amendment filed March 29, 2002, effective May 2, 2002, terminated Oct. 30, 2002. Amended: Filed March 29, 2002, effective Oct. 30, 2002. Amended: Filed May 5, 2003, effective Dec. 30, 2003. Emergency amendment filed August 11, 2005, effective September 16, 2005, expires February 28, 2006. Amended: Filed August 11, 2005.*

DEPARTMENT OF MENTAL HEALTH
Division 10--Director, Department of Mental Health
Chapter 5--General Program Procedures

PROPOSED RULE

9 CSR 10-5.206 Report of Events.

PURPOSE: This rule prescribes procedures for documenting, reporting, analyzing and addressing certain events that affect individuals in residential facilities, day programs or specialized services that are licensed, certified or funded by the Department of Mental Health (department) as required by sections 630.005, 630.020, 630.165, 630.167 and 630.655, RSMo.

(1) The following words and terms, as used in this rule, mean:

(A) Consumer, individual receiving department funded or contracted services--directly from any program or facility;

(B) Corrective Action Plan, the document a provider submits to the department in response to the results of an event or events which outlines those measures that are intended to reduce the likelihood that the event(s) will recur or to remediate a deficiency. Such actions include but are not limited to: removal of an individual receiving services or staff from a provider; staff training; improvements in the physical plant; revision of operating procedures;

(C) Department, the Department of Mental Health's local regional center, district administrator, or supported community living office, depending on the division providing service;

(D) Guardian, individual who is legally responsible for the care and custody of the consumer;

(E) "On Call" system, procedure of the specific regional department personnel being available to receive notification of events during non-business hours. A telephone number is provided to verbally relay this information to the individual representing the specific region and division providing service;

(F) Provider,

1. A residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health (department).

2. Provider does not include residential facilities licensed by the Department of Health and Senior Services under chapter 198 RSMo unless the residential facility is also licensed by the department. In this case this rule applies only to consumers that have a primary diagnosis of mental illness and whose board and care are funded by the department.

3. Duties of the provider under this rule are the responsibility of the chief administrative officer of the residential facility, day program or specialized service, or his/her designee;

(G) Reportable Events, those specific incidents and medication errors identified on the applicable department Report Form dependent on the division providing service to the consumer; and

(H) Report Form, Department of Mental Health form identifying reportable events and the timelines for reporting such events to the department. The form is used for data entry into the department Incident and Investigation Tracking System for statewide data collection. This form is identified as DMH-9719 A (Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services) or DMH-9719 B (Division of Mental Retardation/Developmental Disabilities), dependent on department division of service, which is incorporated by reference and attached to this rule.

(2) This section applies to event notification and reporting requirements for employees of providers, as defined under section 630.005, RSMO. Facilities, programs and services that are operated by the department are regulated by the department's operating regulations and are not included in this definition, because this rule does not apply to department operated facilities.

(A) Providers must maintain written policies requiring their employees to report events under this regulation and those events identified in 9 CSR 10-5.200. The policies must make clear that administrative or disciplinary sanctions may result from failure to report. Providers must ensure that their employees and those who support the agency are educated about the department's notification and reporting requirements.

(B) It is the responsibility of the provider to –

1. Notify the department with a written or verbal report of all events reportable under this regulation involving consumers as identified on the Report Form.

A. For those events requiring immediate notification, if a verbal report, it will be followed up in writing on the Report Form and faxed or otherwise transmitted to arrive within one (1) business day to the appropriate department office. All other events not requiring immediate notification shall be provided in writing on the Report Form in the timeframe specified on the Report Form.

B. The category "Other" on the Report Form is meant to accommodate those unusual events which, in the opinion of the provider, constitute a significant impairment to the health, safety and welfare of the consumer.

2. Notify the department using the department's "On Call" system after 5:00 p.m. or on weekends/holidays for those events on the Report Form requiring immediate department notification, and any event resulting in extensive property damage or major disruption of the program or service the consumer receives; and

3. Within twenty-four (24) hours of knowledge of an event that requires immediate department notification, verbally notify the legal guardian or parent (if consumer is a minor) of the specifics regarding the event. The provider shall also communicate that the event has been reported to the department. The only exception to this verbal notification is if the parent(s) or legal guardian is the suspected primary person involved that forms the basis for the reported event. If the provider is unable to verbally contact the guardian/parent, the provider shall document on the Report Form all efforts made to comply.

(3) The provider shall ensure that patterns and trends of reportable events, specific to a consumer, are included and addressed in the consumer's personal/treatment plan upon approval by the planning team. To the extent that specific consumer issues are identified, the department staff may meet with the provider to discuss action steps to address and resolve issues, including submission of corrective action plans.

(4) The department may request a corrective action plan be provided by the provider based on the facts surrounding the event. This plan is subject to approval by the department within a time frame specified by the department. This plan must be carried out as specified.

(5) Programs licensed or certified by the department must maintain internal records of similar events or information for individuals who do not receive department funded or contracted services, for purposes of quality review to assure that problems are identified and resolved. Non-identifying event records or non-identifying analysis of these events must be available for review by the department as needed for monitoring or licensure/certification activities. This section does not apply to facilities licensed under Chapter 198 RSMo.

(6) Failure to follow the above referenced regulations may result in administrative sanctions up to and including contract cancellation or licensure/certification revocation.

AUTHORITY: sections 630.005, 630.020, 630.165, 630.167 and 630.655, RSMo.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than \$500.00 in the aggregate.

PRIVATE COSTS: This proposed amendment will not cost private entities more than \$500.00 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment by writing to Scott Giovanetti, Investigations Program Director, Department of Mental Health, P.O. Box 687, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Event # _____
DMH Use Only

Department of Mental Health
CIMOR EMT – Community Event Report Form - MRDD

1. Event Date & Time ____/____/____ : ____ <input type="checkbox"/> AM <input type="checkbox"/> PM Month Day Year	2. Discovery Date & Time ____/____/____ : ____ <input type="checkbox"/> AM <input type="checkbox"/> PM (Complete this section only if different than event date/time)
3. Event Location or where discovered (Name of agency or location)	4. Name of Provider Agency/Organization involved in event & VENDOR NUMBER

EVENT CATEGORY (CHECK ONE)	5. <input type="checkbox"/> INCIDENT (Includes Death) <input type="checkbox"/> MEDICATION ERROR
PROGRAM CATEGORY PERTINENT TO EVENT (CHECK ONE)	6. <input type="checkbox"/> CASE MANAGEMENT <input type="checkbox"/> ISL <input type="checkbox"/> GROUP HOME <input type="checkbox"/> PERSONAL ASSISTANT <input type="checkbox"/> SUPPORTED EMPLOYMENT <input type="checkbox"/> DAY HABILITATION <input type="checkbox"/> RESPITE <input type="checkbox"/> OTHER _____ (please list)

7. EVENT/ INCIDENT TYPE (SELECT ONE BELOW) <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Choking (requiring intervention) <input type="checkbox"/> Violation of Consumer Rights <input type="checkbox"/> Consumer struck object resulting in injury <input type="checkbox"/> Elopement when absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return Return Date: ____ Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Found on Floor/ground (not witnessed) <input type="checkbox"/> Fall to floor/ground (witnessed) <input type="checkbox"/> Near Fall (lowered to floor by staff) <input type="checkbox"/> Fire <input type="checkbox"/> Inappropriate language by staff toward consumer </div> <div style="width: 30%;"> <input type="checkbox"/> Ingestion of non-food item <input type="checkbox"/> Medical emergency-Consumer <input type="checkbox"/> Misuse of consumer funds/property <input type="checkbox"/> Physical altercation-between consumers <input type="checkbox"/> Physical altercation-consumer & non-staff <input type="checkbox"/> Physical altercation-Staff & Consumer <input type="checkbox"/> Possession of weapon <input type="checkbox"/> Property loss/destruction <input type="checkbox"/> Sexual conduct-consumer/non-consensual <input type="checkbox"/> Sexual conduct-staff & consumer </div> <div style="width: 30%;"> <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Theft by consumer <input type="checkbox"/> Vehicular accident <input type="checkbox"/> Other _____ Report any of the following three incidents <input type="checkbox"/> Consumer self harm <input type="checkbox"/> Graphic threat of harm <input type="checkbox"/> Seizures only if: • unusual and not being addressed in the personal plan; • there is an injury; or • there is an allegation/suspicion of neglect </div> </div>	8. DID THE EVENT RESULT IN Check all that apply <input type="checkbox"/> Injury to consumer <input type="checkbox"/> Use of physical restraint <input type="checkbox"/> Administration of PRN psychotropic medication <input type="checkbox"/> Hospitalization/non-injury <input type="checkbox"/> Death <input type="checkbox"/> None of the above If injury complete 10, 11 12, 13
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9. Persons Involved (attach pages if necessary)	Relationship	Role	DMH State ID # (for consumers)

Relationship Types: Consumer, Parent, Guardian, Staff, Visitor, Volunteer, Other – specify (list consumer name(s) first and repeat first ID at top of page 2)
Role Types: Alleged Perpetrator (or Responsible Party), Alleged Victim, Complainant, Informant, Witness, Other- specify, (reporter listed in section 19)

10. INJURY TYPE (SELECT ONE) <input type="checkbox"/> Accident <input type="checkbox"/> Consumer Inflicted <input type="checkbox"/> Self Inflicted <input type="checkbox"/> Staff inflicted <input type="checkbox"/> Other Inflicted <input type="checkbox"/> Unknown			
11. INJURY SEVERITY (SELECT ONE) <input type="checkbox"/> No Treatment <input type="checkbox"/> Minor First Aid <input type="checkbox"/> Medical Intervention <input type="checkbox"/> Hospitalization			
12. INJURY DESCRIPTION (CHECK ALL THAT APPLY) <input type="checkbox"/> Abrasion <input type="checkbox"/> Frostbite <input type="checkbox"/> Bite <input type="checkbox"/> Heat related Illness <input type="checkbox"/> Burn <input type="checkbox"/> Puncture <input type="checkbox"/> Bruise/ Contusion <input type="checkbox"/> Scratches <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Cut/ Laceration <input type="checkbox"/> Swelling <input type="checkbox"/> Dislocation <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Fracture/Break	13. INJURED BODY PARTS (CHECK ALL THAT APPLY) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Head <input type="checkbox"/> Shoulder R/L <input type="checkbox"/> Face <input type="checkbox"/> Upper Arm R/L <input type="checkbox"/> Eye R/L <input type="checkbox"/> Elbow R/L <input type="checkbox"/> Ear R/L <input type="checkbox"/> Forearm R/L <input type="checkbox"/> Nose <input type="checkbox"/> Wrist R/L <input type="checkbox"/> Mouth <input type="checkbox"/> Hand R/L <input type="checkbox"/> Teeth <input type="checkbox"/> Chest <input type="checkbox"/> Neck <input type="checkbox"/> Upper Back </div> <div style="width: 45%;"> <input type="checkbox"/> Lower Back <input type="checkbox"/> Abdomen <input type="checkbox"/> Waist <input type="checkbox"/> Hip R/L <input type="checkbox"/> Genitals <input type="checkbox"/> Buttock R/L <input type="checkbox"/> Thigh R/L <input type="checkbox"/> Knee R/L <input type="checkbox"/> Calf R/L <input type="checkbox"/> Shin R/L <input type="checkbox"/> Ankle R/L <input type="checkbox"/> Foot R/L <input type="checkbox"/> Other (specify) _____ </div> </div>	(CIRCLE R or L BELOW) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FINGERS <input type="checkbox"/> Thumb R/L <input type="checkbox"/> Index R/L <input type="checkbox"/> Middle R/L <input type="checkbox"/> Ring R/L <input type="checkbox"/> Little R/L </div> <div style="width: 45%;"> TOES <input type="checkbox"/> Big R/L <input type="checkbox"/> 2nd R/L <input type="checkbox"/> 3rd R/L <input type="checkbox"/> 4th R/L <input type="checkbox"/> Little R/L </div> </div>	
14. MEDICATION ERROR CATEGORY (SELECT ONE) <input type="checkbox"/> Failure to Administer <input type="checkbox"/> Wrong Form		15. MEDICATION ERROR SEVERITY RATING (SELECT ONE) <input type="checkbox"/> Minimal: No treatment or intervention other than monitoring or observation	

Reason _____ <input type="checkbox"/> No Physician Order <input type="checkbox"/> Wrong Dose	<input type="checkbox"/> Wrong Medication <input type="checkbox"/> Wrong Person <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Time	<input type="checkbox"/> Moderate: Treatment and/or interventions in addition to monitoring or observation <input type="checkbox"/> Serious: Life threatening and/or permanent adverse consequences
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EMT MRDD Community Event Report: revised 10-1-2006

(Check one) ☐ **Event** or ☐ **Discovery** Date & Time: _____ : _____ AM/PM Consumer ID: _____

16. NOTIFIED: Persons /Agencies	Name of Person Contacted	Date	Time
<input type="checkbox"/> DMH Regional Center			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Family or Guardian			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Physician			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Law Enforcement			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> DSS Children's Division			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> DHSS			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> 911			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Coroner or Medical Examiner			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Other			____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

17. EVENT DESCRIPTION: Describe what happened and interventions used by staff:

Attach additional pages if necessary

18. IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURENCE (To be completed by agency management)

19. Signature-Reporter	Phone Number ()	Agency Name	Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
20. Signature-Agency Management/Supervisor			Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
21. Signature-Service Coordinator			Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM
22. Signature-Other DMH Staff			Date ____/____/____ ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

23. ACTION/ COMMENTS (To be completed by DMH)

Was the event a Critical Incident?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes to either question, must be entered into EMT within 1 working day
Suspicion or Allegation of Abuse, Neglect or Misuse of Consumer Funds/Property?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
If a death occurred: Suspected Manner of Death <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED				
Was consumer seen by physician within prior 24 hours? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Is an Autopsy being performed? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list Coroner/Medical Examiner: _____				
Check any of the following contacts that are required: <input type="checkbox"/> DMH Facility Head <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Local Law Enforcement <input type="checkbox"/> DHSS <input type="checkbox"/> DSS				
<input type="checkbox"/> Highway Patrol <input type="checkbox"/> Coroner or Medical Examiner <input type="checkbox"/> STAT Team				
Please attach documentation that all required contacts have been made (if contact information is not already included on this form) <u>prior to presenting the form for data entry</u>				

EMT MRDD Community Event Report: revised 10-1-2006

CIMOR EMT – Community Event Report Form - MRDD

Instruction Sheet for the Community Event Report Form 10-1-06

1	Event Date & Time: Date and time the event began/occurred or is believed to have begun/occurred.
2	Discovery Date & Time: Date and time the event was discovered. For example, a bruise on a consumer is discovered but the date of injury is unknown. Complete this section only if different than event date & time.
3	Event Location or where discovered: Agency name or location where the event occurred.
4	Name of Provider Agency/ Organization involved in event & Vendor Number: The organization that may be responsible for the event. This is usually where the event occurred or if not at an organization, the organization with primary oversight responsibility for the individual.
5	Event Category (select one): Check the event type being reported –Incident (Includes Death) or Medication Error
6	Program Category Pertinent to Event (select one): Check the primary service the consumer was receiving at the time of event.
7	Event/Incident Type (select one) – Check the event that occurred. Choking (requiring intervention): When food or an object has obstructed the airway and the Heimlich maneuver or other medical intervention is required to save the life of an individual. Violation of Consumer rights: Any suspected violation of consumer rights as established by RSMO 630.110 or where there is a suspicion or allegation of abuse or neglect. Consumer struck object resulting in injury: Any physical force inflicted upon an object by a consumer. Elopement: When a consumer's absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return. (Record return date and time.) Found on floor/ground (not witnessed): Found consumer on the floor from an apparent loss of an upright or erect position of the body. Fall to floor/ground (witnessed): Sudden loss of an upright or erect position of the body. The fall did not result from any forcible physical actions of another person. Near fall (lowered to floor by staff): Sudden loss of an upright or erect position of the body. Intervention to assist and lower the consumer to the floor was provided. Fire: Starting a fire whether intentional or due to impaired cognition or judgment. Inappropriate language by staff toward consumer: Staff using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a consumer's presence. Ingestion of non-food item: Ingestion of an item that is not food, water, medication or other commonly ingestible item that may constitute a hazard to health. Medical emergency-consumer: A medical emergency occurs while a consumer is receiving active services in a facility, program or in the community with staff. The consumer is sent to a hospital or emergency care clinic in an urgent situation and receives medical treatment. <i>This is used only when another incident type does not first describe the incident.</i> Misuse of consumer funds/property: Staff is suspected to have misappropriated or converted a consumer's funds or property for their own benefit. Physical altercation between consumers: Any physical force inflicted upon a consumer by a consumer. Physical altercation consumer & non staff: Any physical force inflicted upon the other when an altercation occurs between consumer and non-staff. Physical altercation – staff & consumer: Any physical force inflicted upon the other when an altercation occurs between a staff and consumer. Possession of weapon: Having on one's person or in one's room an instrument or an object manufactured or altered to have potential to cause injury to oneself or to another individual. This includes a lighter or matches where/when not allowed. Property loss/destruction: Significant or notable destruction of property. Sexual conduct - consumer/non-consensual: Any sexual act involving a consumer when it is suspected or alleged that one of the parties was not a willing participant. This includes those incapable of giving consent due to guardianship or other reasons.

	<p>Sexual conduct – staff & consumer: Any suspected or alleged sexual conduct between staff and consumer including but not limited to the definition of sexual abuse.</p> <p>Suicide attempt: Any action(s) taken by an individual with the intent to kill oneself but he/she is not successful. Theft by consumer: The act or an instance of stealing committed by a consumer</p> <p>Vehicular accident: Consumer was involved in the collision of a vehicle with another object.</p> <p>Other – Specify any incident not described above.</p> <p>Report the following incidents only if 1) unusual and not being addressed in the personal plan; 2) there is an injury; or 3) there is an allegation/suspicion of neglect.</p> <p>Consumer self-harm: Any physical force inflicted by a consumer on self.</p> <p>Graphic threat of Harm: Any threat, verbal or non verbal, which conveys a significant risk of imminent harm or injury and results in reasonable concern that such harm will actually be inflicted.</p> <p>Seizures – A convulsion or attack of Epilepsy.</p>	
8	Check if event resulted in (Check all that apply)	
	Injury to consumer..... Use of physical restraint..... Administration of PRN psychotropic medication... Hospitalization/non-injury Death None of the above.....	Any physical harm or damage. This does not include naturally occurring physical illnesses or death from natural causes. Any physical intervention technique used to restrict a consumer's movement. Specific division definitions may be found in the applicable Code of State Regulation 9 CSR 40-1.015 Any administration of a medication (pharmacologic agent) that affects a person's mental status that is prescribed but given according to circumstances and not a scheduled time. The incident was not a result of an injury; however, the incident did require that the consumer be admitted as an inpatient to a hospital and assigned to a bed on a unit outside the emergency room. The injury received, or complications from the injury, was so severe that it resulted in the termination of life of the injured individual. The event did not result in one of the above.
9	Persons involved, relationship, role and DMH State ID# (for consumers)	
	Relationship Types: Consumer..... Parent/Guardian..... Staff..... Visitor..... Volunteer..... Other Role Types: Complainant..... Perpetrator..... Reporter..... Victim..... Witness..... Other.....	Any individual receiving services from the Department of Mental Health Individual who is legally responsible for the care and custody of the consumer Agency worker/employee Individual coming to see a person or spending time in a place, whether for social, business or professional reasons. Individual providing services, of his own free will, and receiving no compensation. If other, please specify. Individual making the complaint or allegation. Individual that appears to be responsible for the event; the one who commits an unacceptable act. Individual responsible for completing the event reporting form. Person harmed by or made to suffer from an act, circumstance, agency, or condition. Individual that observed /heard the event. If other, please specify.
10	Injury Type (select one)	

	Accident..... Consumer Inflicted..... Other Inflicted..... Self Inflicted..... Staff Inflicted..... Unknown.....	Unexpected or unintentional occurrence such as slipping on an icy surface or injuries sustained during a seizure. A consumer inflicts physical harm on another person A person that is not staff or consumer, or an animal inflicts physical harm on a person Deliberate action by the person that results in self-harm, such as punching a wall or lacerating the wrists. Staff intentionally or unintentionally inflicts physical harm on a person The cause of the injury is not apparent or evident.
11	Injury Severity (select one) <i>Must be completed if event resulted in an injury (see #8)</i>	
	No Treatment..... Minor First Aid..... Medical Intervention..... Hospitalization.....	Treatment was not needed. Injury was treated by individual trained and/or certified in First Aid. Injury is severe enough to require the treatment of the individual by a licensed physician, osteopath, podiatrist, dentist, physician assistant or nurse practitioner but not serious enough to warrant or require hospitalization. The treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital. Injury is so severe that it requires medical intervention and treatment as well as care of the injured individual at a general acute care hospital. Regardless of the length of stay, this severity level requires that the injured individual be formally admitted as an inpatient to the hospital and assigned to a bed on a unit outside the emergency room.
12	Injury Description (check all that apply) If other, please specify.	
13	Injured Body Part(s) (check all that apply) If other, please specify.	
14	Medication Error Category (check one)	
	Failure to administer... Reason..... No Physician Order..... Wrong dose..... Wrong form..... Wrong medication..... Wrong person..... Wrong route..... Wrong time.....	One or more doses of prescribed medication were not distributed, dispensed or administered as prescribed by the physician. Add the reason that the medication was not administered. One or more doses of medication were distributed, dispensed or administered without the authorization of a physician. More or less of the prescribed amount of medication was distributed, dispensed or administered to the consumer. The medication was administered in a form other than ordered, e.g. tablet instead of concentrate, ointment instead of cream. A different medication than the one prescribed was distributed, dispensed or administered to the consumer One or more doses of medication were distributed, dispensed or administered to a person for whom the medication was not prescribed. The medication was distributed, dispensed, or administered to a person by the wrong route, i.e. by mouth, in ear, in eye, injection, topical, etc. The medication was not distributed, dispensed, or administered at the prescribed time. Current standard of practice is that medication should be administered within 60 minutes prior to or following the prescribed time. As an example, if a medication is prescribed for 8:00 p.m. or the h.s. medication rounds time for a facility is 8:00 p.m., then the acceptable window would allow medications to be administered as early as 7:00 p.m. or as late as 9:00 p.m.

15	Medication Error Severity Rating (select one): Must be completed if there was a medication error. Check the box that describes the severity level. <i>(DMH staff will review and confirm the severity level checked.)</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Minimal Moderate..... Serious..... </div> <div style="width: 65%;"> No treatment or intervention other than monitoring or observation. Treatment and/or interventions in addition to monitoring or observation. Life threatening and/or permanent adverse consequences. </div> </div>
16	Notified: Check persons/agencies notified, along with the person's name and date and time of notification. <i>Note: Department of Mental Health Regional Center notification required.</i>
17	Event Description/Narrative: Describe what happened and interventions used by staff. If there was a medication error, indicate the name(s) of medications involved, including times, dosage, and reason for error.
18	Immediate Action Taken By Agency And Action Steps To Prevent Reoccurrence (to be completed by agency management): Describe the immediate action by agency management as a result of the event. Include disciplinary and/or follow-up action taken to prevent reoccurrence of such events in the future.
19	Signature - Reporter: Name, telephone number and agency name of individual providing the initial information to the department which results in completion of an event report. Report Date/Time: Date and time event report completed.
20	Signature - Agency Management/Supervisor: Indicates that the report was reviewed before being sent to DMH. Report Date/Time: Date and time the event report was reviewed.
21	Signature - Service Coordinator: Indicates that the report was reviewed. Report Date/Time: Date and time event report was reviewed.
22	Signature - Other DMH Staff: This could include Quality Assurance, Supervisors, Director, Abuse & Neglect, or Behavioral Resource Technicians. Report Date/Time: Date and time event report was reviewed.
23	Action/Comments (to be completed by DMH): Indicates action taken by DMH staff upon notification and if the event was a critical incident. Specifies if there is suspicion or allegation of abuse, neglect or misuse of consumer funds/property. If a death occurred, the suspected manner of death and whether or not an autopsy will be performed (if yes, must list coroner/medical examiner). Designates contacts to required entities.



QMRP

DOCUMENTATION

Daily Progress Notes

The daily progress note is the building block for quality care and monitoring. The daily progress note should be completed on each shift. The staff member who writes the monthly report uses the daily progress note to incorporate pertinent information. The monthly report is only as good as the information that is contained in the daily progress note.

What else can daily progress notes be used for?

- The daily progress note is also used for staff to convey important information about that person to the next shift.
- It can be used as a check and balance system, for
 - administration of medications,
 - to ensure needed appointments were made for the person,
 - and to ensure that outcomes are being worked on.
- It is also the place to look for important information on the person to make certain the information is kept current and is incorporated into the Personal Plan.
- Information documented on the daily report should be useful and detailed. Words such as "good", "bad", "no problems", etc. should be avoided. These words do not tell the reader useful information. Describe to the reader what "good" is.

For instance, instead of ____ had a good day, describe the person's day and what made the day good.

- Information documented should reflect the time spent with the consumer excluding the objectives.
 - Where they went, etc.

The note also helps leave a paper trail for any liability issues the agency may experience, or any possible abuse and neglect situations.

Finally, the note contains important information about a person to help maintain the health, safety and welfare of the person, and to support them in making their life rich and meaningful. This reinforces what is in the Personal Plan.

Monthly Review

The monthly summaries describe progress on the individual person centered plan goals and objectives and overall status of the individual.

The QMRP will get info from daily progress notes to develop the monthly review. Monthly reviews will help develop annual plan and objectives

The following should be included in the monthly review:

- Self Determination (Behavioral issues: document any behavioral concerns including types of behaviors; comments as to whether support plan is working; a general reference to occurrences as reported on event reports; and systems issues)
- Health/Medical (Doctor Appointments, medication changes, hospitalizations, general health changes, weight changes, health concerns)
- Rights (Family/Guardian Contacts and Visits)
- Community Activities
- Overall Program Progress/Concerns/Changes Needed and Provider/QMRP Objective Review:

In this section the provider should document each outcome and action step as it is written in the personal plan. The provider is required to show progress or lack of for each action step and if there is no progress, why. This information should be specific so that it directly relates back to the overall outcome the person desires. If the outcome is completed the provider documents on this section, and will not need to include this specific outcome on future monthly reports.
- Casemanager Objectives, comments, concerns
- Client Visited Programming Observed (dates)
- Signature/date (line for QMRP or Administrator and a line for the Casemanager, and there can be a line for the consumer if applicable.

State of Missouri
Department of Mental Health
IP Monthly Review

For the Month of		Provider/Service
Client Name	Case Number	IP Implementation Date

Monthly data grid must be attached.

Health/Medical: (List all doctor appointments/results, follow up appointments/results, medication changes and reasons, hospitalizations, general health changes, weight changes, health concerns, lab results, dental work, etc...)
Behavior/Self Determination/Rights: (List changes positive/negative, if a behavior support plan is in place, is it working? If have a rights restriction- is plan working, needing change?)
Family/Guardian Contact: (List visits & phone contacts. Any concerns?)
Community Activities: (List community activities & summary of the activity.)

Overall Program Progress/Concerns/Changes needed: (List each objective by number/letter with a brief summary of progress or need for change. Comment on attached data sheet month of change in objective and change made)
Case Manger Comments and Changes Needed to IP: (Case Manger should summarize information gathered from the meeting with the provider.)
___ Continues to make progress as outlined in the current Individual Plan and the team members believe the plan continues to be appropriate.
___ Continues to make progress as outlined in the current Individual Plan but changes are needed and team meeting will be scheduled to address changes/issues.
___ Is not making progress as projected in the current Individual Plan and changes are needed and team meeting will be scheduled to address changes/issues.
___ Is not making progress as projected in the current Individual Plan. While no changes are recommended at this time, the Individual Plan team will continue to monitor the plan and services.
Case Manger observation/visit with client: (date and place)

Provider/QMRP signature

Date

Case Manager signature

Date

**THE FOLLOWING WILL BE INCLUDED ON IP MONTHLY REVIEWS FOR ALL
OBJECTIVES:**

- What date the objective was done
- What level of support was needed
- What the person did for the objective
- Progress made
- Recommendations

Examples: Obj. 1--Went with staff to McDonald's on the 14th, 20th, and 26th for lunch. He was verbally assisted in ordering his lunch but independently carried it back to his seat and ate with supervision and needed intermittent reminders to slow down and use his napkin. He really liked the fries.

Obj. 2--He went to the YMCA on the 3rd, 15th, and 22nd to exercise. He was continually verbally prompted to walk the treadmill for 30 minutes, but walked around the track independently.

Obj. 3—Needs physical assistance when washing her hands every day before meals, staff applies soap and she will scrub, staff then puts her hands under the faucet to wash them off, and she will dry her hands when staff hands her paper towels.

MONTHLY DATA GRID

	/	/	/	/	/	/	/	/	/	/	/	/	Comments
Obj. __													
Obj. __													
Obj. __													
Obj. __													
Obj. __													
Obj. __													

13.9 ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (1)(A) defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered, with the exception of in-home services such as personal care, home health, etc.

For MRDD providers, reference to "medical records" should be equated to individual records the provider maintains that include the person's plan of care, progress notes, medical information, dates of service, units of service provided, type of service provided and person providing the service.

13.9.A DOCUMENTATION

Implementation of services *must* be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized supported living and at least quarterly for individuals who live in their natural home. The provider is required to document the provision of MRDD Waiver services by maintaining:

- attendance or census records documenting days of service signed by the provider or designated staff;
- daily activity records that describe various covered activities (services) in which each person participated; records of which staff provided each unit of service; documentation that each such staff is qualified to provide the service;
- progress notes by direct care staff regarding situations or incidents (good or bad) that arise affecting the individual;
- monthly summaries that describe progress on the individual's person centered plan goals and objectives and overall status of the individual; and
- a written annual assessment addressing progress and specific recommendations for service in conjunction with the individual's Personal Plan review.

All providers must follow the above documentation requirements unless otherwise noted under specific MRDD Waiver services in Sections 13.16 through 13.33. Any additional requirements for a specific service are also included in these sections.

Personal Plan

A document resulting from a process directed by the individual served, with assistance as needed by a representative.

- It is intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant.
- The process may include other individuals freely chosen by the participant who are able to serve as contributors to the process.
- The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes.

A person centered plan (PCP) is a consumer's plan which:

- Is an annual plan
- Drives the services for the consumer
- Every consumer has one
- Goals and Objectives are found in this plan
- Is a legal document
- A functional assessment (provider personal plan preparation tool) is completed to help develop the plan

Training Plan

How data will be collected when working on an outcome with a consumer. This plan describes the process, so each staff approaches the training of the outcome in the same manner to keep consistency and structure for the consumer.

Training Plans should include the following:

1. Name of consumer
2. Objective as stated in annual plan
3. Time estimated for training:
 - Start date (should match annual plan date)
 - Targeted Date of Completion (should match annual plan date.
If date is passed, there should be an amendment completed)
4. Methods to be used
 - Training strategy (what support staff will do)
 - What consumer is expected to do
 - What success looks like
5. Materials to be used
6. Method of data collection and review
7. Person responsible for the training



QMRP
FINANCIAL

MANAGEMENT OF CONSUMER FUNDS

Consumer funds are to be held in trust and not commingled with provider funds. Reimbursements to the provider should not be deducted from consumer's account. Requests for reimbursements should be sent to the Regional Center. If one bank account is maintained for all consumers, separate ledgers must be maintained for each consumer. Ledger sheets should show **deposits, expenditures, and beginning and ending balances.**

Deposits

1. Deposits include:

- a. Personal allowance (shown on first DMH-57). This amount remains the same unless you receive a new DMH-57.
- b. Net wages are received.
- c. Money for specific purpose - included DMH-57 or paid by separate check. Documentation of the purpose should be included with the payment. These funds are to be used only for the purpose specified.
- d. Gifts of money.

2. Deposits should be made and recorded on the consumer's ledger within 5 working days of receipt of the funds.

Expenditures

1. Expenditures should meaningfully benefit the consumer.
2. Expenditures should be recorded when the purchase is made.
3. Any purchase of \$100 or more for one or a group of like items (i.e. clothing) requires written approval by the Department.
4. All property purchased for a consumer belongs to that consumer. The property should be kept in the consumer's immediate living area or, if this is not practical, in an area the consumer can easily access. It should not be used by anyone else without the permission of the consumer. A record of each purchase shall be maintained in the consumer's file at the provider's facility.
5. The consumer's or conservator's signature is required for any cash distribution from a consumer's personal funds of \$10 or more.
6. A receipt is required for purchases of \$10 or more. This documentation should be retained by the provider. Providers are encouraged to make purchases by check if at all possible.
7. No charge can be made by the provider for maintaining a consumer's bank account. The consumer's account may be charged for regular check-writing charges.

Overdrafts are the responsibility of the provider.

8. The consumer should not pay for items the provider is required to provide.
9. Expenditures should be itemized on the consumer's ledger and PFFR (personal Funds Financial Report) showing the date, description of items purchased, and Amount spent.
10. Wage assessments should be shown as an expenditure on the consumer's ledger and PFFR when these funds are collected by the provider.

Balances

1. The Department of Mental Health is not responsible for deficit spending.
2. Funds in excess of \$200 at the end of each quarter must be returned to the Regional Center unless special arrangements are made through written agreements.
3. Within 30 days of the death or transfer of a consumer, the provider shall return the consumer's funds to the Regional Center. This does not apply to nursing home Consumers. These funds should be returned to DFS (Division of Family Services)

Record-Keeping

1. Providers are required to submit quarterly PFFRs (Personal Funds Financial reports) on each consumer living at their facility. This form will show deposits, Expenditures, and balances for the quarter.
2. The schedule for submitting PFFRs is as follows:

July, August, September	-due October 31
October, November, December	-due January 31
January, February, March	-due April 30
April, May, June	-due July 31
3. Each month, the provider should reconcile the bank statement balance with the checkbook balance and the consumer's ledger sheets.
4. Check numbers should be written on the receipt, the ledger, and the PFFR.
5. Consumers will have access to records of their personal funds and accounting procedures at the provider facility.

PLEASE REFER TO THE "MANAGEMENT OF CONSUMER PROPERTIES" SECTION OF YOUR CONTRACT FOR ADDITIONAL INFORMATION.

Medical Ancillaries

1. One-time medications can be purchased from the consumer's account. However, medication should not routinely be purchased from the consumer's account.
2. Funds received for on-going medications should be maintained separately from consumer funds. A separate quarterly PFFR is required for on-going medications. This should document deposit, expenditures, and balances. Documentation of Expenditures should be retained by the provider.
3. Account balances in excess of 2 times the monthly payment for medications should be returned to the Regional Center at the end of the quarter.
4. Within 30 days of the death or transfer of a consumer, the provider shall return all remaining funds to the Regional Center.

Petty Cash

Cash kept in the home on behalf of the client should be kept separate from the home's own petty cash account. Petty cash for clients should only be used for the client to whom it belongs. When cash is given to a client, he or she should sign for the cash. If possible, provide receipt. The amount of cash kept at the home should be no more than the amount the client would spend for incidental expenses (i.e. sodas, chips, and snacks) for a week. When more funds are needed, the petty cash should be reconciled and receipts put into a separate envelope marked for the prior week.

If the provider maintains a petty cash account for the clients, we recommend that a separate record be maintained. In this way, the provider can reconcile the bank balance to the client funds ledgers and the petty cash balance to separate ledgers. The provider must account for this information by client. The combined bank and petty cash balance should not exceed \$200.00.

ISL ROOM AND BOARD

Money that is authorized and funded through an ISL budget belongs to the client not the provider. Any excess Room and Board at the end of the month goes against the \$999 total that a client can have in funds according to Medicaid rules. The provider should not use the money belonging to one client to defray the expenses of another client. Separate records for each client should be maintained.

Room and Board funds are to be used for those items listed on the left side of the budget. No other expenditures are authorized to come from these funds.

The balance of individual room and board funds along with any other accounts belonging to the client should not exceed \$200 at the end of the quarter. Funds in excess of this amount should be returned to the Regional Center. It is very important to pay Room and Board bills promptly to not show an excess unnecessarily. Please note that budgets can be adjusted throughout the year to reduce the amount of Room and Board if the change is more than \$4 per day. Annual ISL budgets are due at the Regional Center by the 15th of the month before the implementation date. ISL budgets submitted to the Regional Center will be accompanied by a staffing pattern showing the number of staff and the number of hours per day worked by each direct care staff.

For any client living in an ISL, a quarterly report is required showing deposits, expenditures, and beginning and ending balances. ISL room and board funds must be accounted for on a separate ledger from the client's personal spending funds.

Within 30 days of the death or transfer of a client, the provider must return all remaining funds to the Regional Center. When a client dies, funds in the room and board account are also frozen. Do not pay any bills from this account.

FREQUENTLY ASKED QUESTIONS

Why do we have to complete PFFRs?

The contract requires it. Please refer to the "Management of Client Properties" in facilities contract with Department of Mental health. As representative payee, we have to account for all funds to Social Security.

Why do we need to do ISL Room and Board PFFRs?

Again, the contract requires it. Room and Board money is considered client funds. Therefore, the same guidelines apply for ISL Room and Board funds and Client personal spending funds. However, the provider must maintain separate records.

I track room and board costs for the entire ISL. Why do I have to report this to you by client?

The funds in the Room and Board account belong to the client and must be accounted for separately. It is possible that the costs would not be the same for all the individuals living in the ISL.

Why can the clients only have \$200 in their personal account?

This is an Official Directive from the Community Service Manual, Chapter Title: Residential Program Contracting and Monitoring; Section Title: Client Funds Policy #4.6. The balance in all accounts must remain under the \$999.00 resource limit in order to retain Medicaid eligibility. The Regional Center maintains a balance no greater than \$700.00 in order to meet the needs of the client including room and board, personal spending, etc.

How can a client save for a large purchase?

Unfortunately, they cannot and remain Medicaid eligible. The asset maximum for Medicaid is \$999. However, lay-away or rent to own may be options. A loan, which the client could repay with his or her wages over time, is also a possibility.

If this client has over \$200 in his account, can we buy gift certificates to reduce the balance?

No. A gift certificate would be considered an asset that would count towards the \$999.00 asset

What constitutes an asset that would count against the \$999.00 limit?

Cash, savings accounts, checking accounts, gift certificates, stocks, bonds, and personal property such as rental property, business equipment, farm machinery, grain, livestock, life insurance with a cash surrender value, boats.

Is a burial account considered an asset?

Burial accounts are considered assets, and there is a question to answer on the Medicaid form concerning burial accounts. The first \$1,500.00 is exempt, but any amount above this counts towards the \$999.00 limit. If the burial policy is irrevocable, however, nothing is counted towards the \$999.00 limit.

What does not constitute an asset?

The home you live in, the automobile you drive (only one), household furnishings in use, and wedding jewelry.

We maintain a petty cash account separate from the bank account. What reporting is required for this?

Keep a petty cash log, showing the ending balance. This amount along with the bank account balance must be under \$200.00 limit.

Why can't people have their own money? It goes from the Regional Center to the provider.

As representative payee, we must account for all money to Social Security. Contractually, the provider is then responsible to account for those funds. If the client is able to handle his or her own money, we can assist them in acquiring this responsibility (becoming payee). However, this is often difficult to accomplish.

I received two checks from the Department of Mental health. How do I know how much money to deposit in the client's account?

A DMH 57 for each client will be included with the Community Placement statement. This will tell you how much to deposit in the personal account, medical ancillary account (if applicable), and the ISL room and board account (if applicable).

What do you look for in an audit?

The standard objectives for monitoring client funds are:

1. To determine the accuracy of client accounts.
2. To determine whether the provider is in compliance with Department policies.
3. To determine whether adequate controls exist to ensure compliance with applicable

STAFFING PATTERNS

1. All individual Supported Living (ISL) budgets submitted to the Regional Center will be accompanied by a staffing pattern showing the number of staff and the number of hours per day worked by each direct care staff. The staffing pattern shall reflect the number of direct care staff hours stated on the ISL budget.
2. A typical ISL staffing pattern will be 1-3 ratio. The individual planning team may request additional staffing for circumstances where the consumers have severe behavioral problems, extraordinary medical needs, additional community supports needs or other things. Staffing patterns must reflect all staff and when the supports are provided to the consumer(s) to match the number of hours on the ISL budget. It is the responsibility of the QMRP to review all ISL budgets together to determine the overall ISL staffing pattern for direct staff.
3. QMRP staffing patterns shall be submitted separately for each budget. The QMRP will review the ISL budgets together to determine the overall ISL staffing pattern for the QMRP. This is especially important if the QMRP supports more than one ISL.
4. Group Homes have different staffing ratios based on the level of care needed by the individuals living in the home. The expectation is that the ratio will be as follows:
 - a. Level III—1-3, 1-3, 1-6. Level III homes will have awake staff at night unless approved by the IP team to have sleep staff at night. A copy of the documentation for the exception shall be included in the Provider file at the regional center.
 - b. Level II -1-4, 1-4, 1-8. Level II homes may have additional staffing for special needs for the consumers as documented in the IP. The night shift is sleep staff unless otherwise stated in the IP.
 - c. Level I—1-8, 1-8, and 1-16. The night shift is sleep staff.
5. QMRP staffing requirements are as follows:
 - a. Level III—2.5 hours per consumer per week
 - b. Level II—2.5 hours per consumer per week.
 - c. Level I—1.66 hours per consumer per week.

Staffing patterns will be monitored by the service coordinator during monthly visits.



QMRP

MEDICAL

MEDICAL RESOURCES

This section of the manual is intended to serve as a resource for the QMRP. As the person who is responsible for oversight of all that is related to the consumer, the medical resources included should be helpful in understanding the roles and responsibilities of the community registered nurse. It is by no means a conclusive of all the functions of the registered nurse, but is meant to help enlighten the QMRP with what may be entailed in monitoring for the health and safety of the individuals we serve.

The information shared in this manual was derived from research based materials and recommended texts. These are listed for your use in the Reference Section.

HEALTH REFERENCE MANUAL

This manual was developed to be used as a resource for the Regional Center nurses as they complete Nursing Reviews. It was designed to reflect each category of the Health Inventory with definition, complications, guidelines for providers, and teaching considerations. The manual can be used by service coordinators, Community RN's, providers, and anyone who supports individuals with MRDD. By using this manual it will ensure consistency of expectations when addressing specific health care needs of the consumers in community placement. This manual may also serve as a useful tool for providers in establishing agency guidelines and identify training needs to support the recommendations for annual personal plans.

The guidelines listed in the Health Reference Manual should not be considered standards of care, but descriptions of the interventions needed to safeguard the health and safety of the individuals we serve.

The Health Reference Manual is not intended to replace individual-specific instructions provided to caregivers nor is it intended to replace proficiency-based training of caregivers that may be required to manage an identified need of an individual.

The information shared in this manual was derived from research based materials and recommended texts. These are listed for your use in the Reference Section.

This manual is online and can be downloaded by going to the RN web page, clicking on prevention, and then click on Health Reference Manual. That web site is- <http://www.dmh.mo.gov/mrdd/nurses/rnhome.htm> - click on prevention and you will find the Health Reference Manual there!

A Reference Guide for Drug Monitoring

A Reference Guide for Drug Monitoring

Reference:

🕒 -Frequency of lab/test

📖 -Needs to be listed in the Medical Section of the Personal Plan

CBC-Complete Blood Count

Drug Categories and Tests Needed

(Refer to Drug Handbook or <http://druginfonet.com> for medications that are not listed.)

I. Anticonvulsants-Seizure medications/can be used for mood stabilizer

📖 Antiepileptic drug toxicity/poisoning is an adverse and health threatening consequence of seizure drug therapy.

Drug	Tests Needed
Tegretol	Drug level, CBC, renal & liver function
Phenobarbital	Drug level, liver function
Dilantin	Drug level, CBC, liver function

📖 Observe seizure activity; mental status; oral status with Dilantin; ask physician for signs/symptoms of blood cell abnormalities to monitor.

🕒 Labs are usually drawn every month for the first 3 months and then every 3-6 months as ordered by physician.

II. Antibiotics/Anti-Infectives

📖 See Signs/Symptoms of adverse side effects on last page.

Drug	Tests Needed
Cephalosporins	Vital signs, encourage fluids
Penicillin's	Vital signs daily
Sulfonamides	Temperature, encourage fluids
Tetracycline's	Temperature daily

📖 Observe for signs/symptoms of allergic reaction; secondary infection; low urinary output and renal failure while individual is taking this medicine. Observe for improvement and report to the physician if the infection is not getting better.

II. Antihypertensives-High Blood Pressure

Drug	Tests Needed
Capoten	BP/P (BP & pulse)
Catapres	BP/P
Apresoline	BP/P, weight weekly
Aldomet	BP/P, weight weekly

📖 Observe for edema and renal function (urinary output). Observe for signs/symptoms of Congestive Heart Failure (moist breath sounds, swelling of feet, see last page for others). Report all side effects to the physician.

III. Antihypertensives-High Blood Pressure (Con't)

🕒 Ask physician about necessary labs and the frequency to monitor (CBC, renal function, lytes or potassium). Take BP/P before starting medications then weekly. Labs vary with medications/physicians.

IV. Antipsychotics/Neuroleptics -Behavior Meds

Drug	Tests Needed
Risperdol	Liver function test every 3 mo's
Zyprexa	CBC every 3 mo's
Haldol	Check for side effects every 6 mo's

📖 Side effects:

- * Pseudo-Parkinsonism-drooling, mask-like facial expression, tremors of the had, pill-rolling, shuffling gait or walk.
- * Tardive Dyskinesia-rhythmic involuntary movements of the tongue, face, mouth, jaw. Protrusion of tongue, puffing of cheeks, puckering of the mouth and chewing movements.
- * Akinesia-decreased voluntary motion, complaints of fatigue, weakness of legs/arms, slowing of voluntary movement.
- * Akathisia-agitation, jitteriness, a feeling of restlessness and tapping of feet. Can occur within 2-3 days or several weeks after drug therapy is started.

📖 Planned precautions should include:

- ✓ observe for urinary retention
- ✓ increase fluids to avoid constipation
- ✓ treat dry mouth with sips of water or hard candy
- ✓ avoid hot baths as this may cause dizziness
- ✓ avoid hot weather /situations that may lead to heat stroke
- ✓ wear sunscreen when out of doors to avoid sunburn
- ✓ monitor for side effects with an approved tool (AIMS or DISCUS) test
- ✓ check the drug handbook to learn the functional class of all behavior medications

IV. Cardiac Drugs-Heart Meds

📖 Cardiac Glycoside: Take pulse before administering- take for 1 minute apically

Drug	Tests Needed
Digitalis/Lanoxin	Weight weekly-report variance

📖 These meds increase blood/oxygen to the heart and slow/strengthen contractions of the heart muscle. Observe for edema. Hold medication if pulse is below 60 BPM (beats per minute) in adults. Take pulse again in 1 hour. If pulse remains below 60, notify physician.

🕒 Labs include: serum drug level, electrolytes, BUN creatinine. Drug level is usually ordered every 3-6 months.

📖 *Observe for loss of appetite-This is a sign of toxicity.

🕒 Beta Blockers lab: Kidney (renal) function; pulse daily.

Tests Needed

(Propanolol Inderal)	BP/weight weekly-report variance
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📖 These meds affect the heart muscle by blocking agents that constrict blood vessels. Notify physician if pulse is below 50. Observe for low BP, dizziness, edema. 🕒 Ask physician about labs-this may vary.

Calcium Channel Blockers-Relaxes heart muscle

Tests Needed

(Calan, Isoptin)	lab: electrolytes, ECG, Blood Pressure, Pulse , Respirations baseline-take pulse daily before administration of the meds
------------------	---

📖 Report changes in vital signs, observe for low BP, dizziness, low urinary output. Report low pulse or change. Take pulse daily before administration of the meds

Procainamide

Tests Needed

(Pronestyl)	Electrolytes, blood glucose in diabetic, baseline Blood Pressure, Pulse and then BP daily
-------------	---

🕒 Ask physician about CBC every 2 weeks for 3 months and then every 3-6 months.

📖 Report increased pulse and/or increased respirations. Monitor for change in amount of fluids taken in and urine output.

Quinidine Gluconate

Tests Needed

(Quinaglute)	Electrolytes, Blood Pressure and Pulse
--------------	--

📖 Report increased respirations/increased pulse and changes from baseline.

🕒 Ask physician about lab and frequencies as it may vary.

V. Diuretics-Fluid pills/remove fluid from the body. Used for high blood pressure or swelling.

Drug

Tests Needed

Loop-Lasix, Furosemide	Labs: electrolytes, renal function
Thiazide-hetz	Weekly BP, weight, urinary output

🕒 Tests should be every 3-6 months. Ask physician about need for potassium level.

V. Diuretics-Fluid pills/remove fluid from the body. Used for high blood pressure or swelling. (Con't)

📖 Observe for edema (swelling), dehydration, take drug early in the day to avoid frequent urination at night. Observe for signs/symptoms of low potassium level (dizziness, low BP, Nausea, Vomiting, Diarrhea) as medication may “flush out” too much potassium.

VI. Anticoagulants-Blood thinners

Drug	Tests Needed
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Warfarin Coumadin	Prothrombin time(P.T.), Hct/platelets monthly
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📖 Thins blood and reduces blood clotting to prevent “strokes” and “clots”. Observe for bleeding gums, nosebleeds, bruising, black tarry stools, fever, rash. Medication must be taken exactly as prescribed. Report refusals of med/missed doses. Long term use of alcohol can affect liver and P.T. The prothrombin time measures how long it takes the blood to clot. Avoid use of aspirin products.

VII. Thyroid Hormones-used to treat low levels of thyroid

🕒 Labs: Thyroid levels every 3-6 weeks, monitor Blood Pressure/Pulse periodically, weekly weight-report changes to the physician.

📖 Report excitability and anxiety which indicate overdose. Avoid iodine in foods and iodized salt. Observe for levels becoming “too high”. Person will have a fast pulse and appear “hyper”.

VIII. Antidepressants (several classes)-Nerve/Depression meds

🕒 📖 Labs: CBC, cardiac enzymes if long-term therapy (over 90 days), serum drug levels, liver and renal function. Observe baseline VS, Blood Pressure weekly, weight weekly, monitor bowel and bladder function, behavior and mental status. Do not stop abruptly. Look for improvement.

IX. Antianxiety-Nerve meds

🕒 Labs: CBC, liver function-ask physician. Vital signs before starting this medicine, BP weekly. Report change in BP to physician. Observe behavior/mental status, bowel and bladder function. Report if there is no improvement.

Signs/Symptoms of Common Side Effects Related to Medication Use

Dehydration	Low Potassium	Congestive Heart Failure	Seizure, Antiepileptic Drug Toxicity
Fast pulse	Dizziness	Shortness of breath	Increased sleepiness
Low BP	Low BP	Slight cough	Inability to concentrate
Increased respirations	Irregular heartbeat	Fatigue	Marked rash
Warm, dry or flushed skin	Nausea, vomiting, diarrhea	Slight abdominal pain	Irritability and/or an increase or decrease in behavioral episodes
Poor turgor	Abdominal distention	Swelling of feet and ankles	Change in skin color (yellowish)
Eyes may appear hollow or sunken	Decreased digestion		Refusing meals
	Slowing of bowels		Vomiting/stomach pain
	Muscle weakness		Decreased urinary output
	Leg cramps		Itching
			Increased bruising

Source: Mosby's Nursing Drug Reference

MEDICATION
Quality Assurance Checklist
Adapted from the Practicum for Level One Med Aides

Student Name: _____ Level One Medication Aide certificate number: _____

Competency	Yes/No	Comments
1. Does the staff compare physician's order to medication records?		
2. Does the staff note any discrepancies?		
3. Does the staff assemble necessary equipment/supplies?		
4. Does the staff demonstrate how to utilize side effect print out sheets?		
5. Does the staff properly identify the individual they will be administering medication to?		
6. Does the staff prepare all medications according to medication record i.e. time, correct meds, correct number of pills, correct dosage?		
7. Does the staff verify consumption?		
8. Does the staff document correctly medication given?		
9. Does the staff demonstrate proper protocol if medication given causes any adverse reactions?		
10. Does the staff have an understanding of administering prn medication?		
11. Does the staff have an understanding of documentation of prn medication and the follow up needed?		
1. Does the staff demonstrate an understanding of taking and documenting vital signs?		
2. Does the staff demonstrate knowledge of proper storage of medication?(medication separated by route)		
3. Does the staff demonstrate knowledge of controlled substances being double locked?		
4. Does the staff know demonstrate an understanding of signing out controlled substances?		
5. Does the staff demonstrate an understanding of what constitutes a medication error?		
6. Does the staff know when to complete a community event report?		
7. Does the staff demonstrate an understanding of proper techniques needed for infection control? Includes proper hand-washing, donning and removal of gloves.		
8. Does the staff demonstrate an understanding of the diagnosis for the medication being administered?		
9. Does the student demonstrate an understanding of transcription of order including D/C and new orders?		

QMRP Signature

Date

CONTROLLED SUBSTANCE COUNT SHEET

Client: _____

Case No: _____

Name/Dosage of Drug:_____

[illegible]

Commonly Prescribed Psychotropic Medications

Antipsychotics <i>(used in the treatment of schizophrenia and mania)</i>	Anti-depressants	Anti-obsessive Agents
Typical Antipsychotics Haldol (haloperidol) Loxitane (loxapine) Mellaril (thioridazine) Moban (molindone) Navane (thiothixene) Prolixin (fluphenazine) Serentil (mesoridazine) Stelazine (trifluoperazine) Thorazine (chlorpromazine) Trilafon (perphenazine)	Tricyclics *Anafranil (clomipramine) Asendin (amoxapine) Elavil (amitriptyline) Norpramin (desipramine) Pamelor (nortriptyline) Sinequan (doxepin) Surmontil (trimipramine) Tofranil (imipramine) Vivactil (protriptyline)	Anafranil (clomipramine) Luvox (fluvoxamine) Paxil (paroxetine) Prozac (fluoxetine) Zoloft (sertraline)
Atypical Antipsychotics Abilify (aripiprazole) Clozaril (clozapine) Risperdal (risperidone) Seroquel (quetiapine) Zyprexa (olanzapine)	SSRIs Celexa (citalopram) Lexapro (escitalopram) *Luvox (fluvoxamine) Paxil (paroxetine) Prozac (fluoxetine) Zoloft (sertraline)	Antianxiety Agents Ativan (lorazepam) BuSpar (buspirone) Centrax (prazepam) *Inderal (propranolol) *Klonopin (clonazepam) Lexapro (escitalopram) Librium (chlordiazepoxide) Serax (oxazepam) *Tenormin (atenolol) Tranxene (clorazepate) Valium (diazepam) Xanax (alprazolam) <i>*Antidepressants, especially SSRIs, are also used in the treatment of anxiety.</i>
Mood Stabilizers <i>(used in the treatment of bipolar disorder)</i> Depakene (valproic acid) Depakote Eskalith Lithobid (lithium) Lithonate Lithotabs *Lamictal (lamotrigine) *Neurontin (gabapentin) *Tegretol (carbamazepine) *Topamax (topiramate)	MAOIs Nardil (phenelzine) Parnate (tranylcypromine)	Stimulants (used in the treatment of ADHD) Adderall (amphetamine and dextroamphetamine) Cylert (<i>pemoline</i>) Dexedrine (dextroamphetamine) Ritalin (methylphenidate) <i>*Antidepressants with stimulant properties, such as Norpramin and Wellbutrin, are also used in the treatment of ADHD</i>
	Others Desyrel (trazadone) Effexor (venlafaxine) Remeron (mirtazapine) Serzone (nefazodone) Wellbutrin (bupropion)	
	Anti-Panic Agents Klonopin (clonazepam) Paxil (paroxetine) Xanax (alprazolam) Zoloft (sertraline) <i>*Antidepressants are also used in treatment of panic disorder</i>	

**Although this medication has been approved by the FDA for the treatment of other disorders, it has not been approved for this particular use. Some evidence of this medication's efficacy for such use does exist however. This type of medication use is referred to as "off label."*

Remember, always consult your doctor or pharmacist with any specific medication questions

*The chart below provides cross-referencing by generic name. ** Indicates medication may be associated with Tardive Dyskinesia, this is not an exhausted list. Other medications that have been associated with Tardive Dyskinesia include Gastrointestinal Medications and Bowel Medications.*

Generic Name	Brand Name	Current Uses
alprazolam	Xanax	anxiety, panic
** amitriptyline	Elavil, Endep	depression (tricyclic)
** amoxapine	Asendin	psychotic depression
amphetamine	Adderall	ADD
aripiprazole	Abilify	schizophrenia (atypical)
bupropion	Wellbutrin	depression, ADD
bupirone	BuSpar	anxiety
** carbamazepine	Tegretol	bipolar disorder
clorazepoxide	Librium	anxiety
** chlorpromazine	Thorazine	schizophrenia (typical)
citalopram hydrobromide	Celexa	depression (SSRI)
clomipramine	Anafranil	OCD, depression (tricyclic)
** clonazepam	Klonopin	anxiety
clorazepate	Tranxene	anxiety
** clozapine	Clorazil	schizophrenia (atypical)
** desipramine	Norpramin	depression (tricyclic), ADD
dextroamphetamine	Adderall, Dexedrine	ADD
diazepam	Valium	anxiety
** divalproex sodium	Depakote	bipolar disorder
** doxepin	Adapin, Sinequan	depression (tricyclic)
escitalopram	Lexapro	depression (SSRI), anxiety
fluoxetine	Prozac	depression (SSRI), OCD, panic
** fluphenazine	Prolixin, Prolixin Decanoate	schizophrenia (typical)
fluvoxamine	Luvox	OCD, depression (SSRI)
** haloperidol	Haldol, Haldol Decanoate	schizophrenia (typical)
** imipramine	Tofranil	depression (tricyclic), panic
lithium carbonate	Eskalith, Lithobid	bipolar disorder
lithium citrate	Cibalith S	bipolar disorder
** lorazepam	Ativan	anxiety
** loxapine	Loxitane	schizophrenia (typical)
maprotiline	Ludiomil	depression (tricyclic)
** mesoridazine	Serentil	schizophrenia (typical)

** methylphenidate	Ritalin	ADD
mirtazapine	Remeron	depression
** molindone	Moban	schizophrenia (typical)
nefazodone	Serzone	depression
** nortriptyline	Pamelor	depression (tricyclic)
** olanzapine	Zyprexa	schizophrenia (atypical)
oxazepam	Serax	anxiety
paroxetine	Paxil	depression (SSRI), OCD, panic
** pemoline	Cylert	ADD
** perphenazine	Trilafon	schizophrenia (typical)
phenelzine	Nardil	depression (MAOI)
prazepam	Centrax	anxiety
** prochlorperazine	Compazine	schizophrenia (typical)
protriptyline	Vivactil	depression (tricyclic)
quetiapine	Seroquel	schizophrenia (atypical)
** risperidone	Risperdal	schizophrenia (atypical)
sertraline	Zoloft	depression (SSRI), ODC, panic
** thioridazine	Mellaril	schizophrenia (typical)
** thiothixene	Navane	schizophrenia (typical)
tranylcypromine sulfate	Prarnate	depression (MAOI)
trazodone	Desyrel	depression (tricyclic)
** trifluoperazine	Stelazine, Vesprin	schizophrenia (typical)
trimipramine	Surmontil	depression (tricyclic)
** valproic acid	Depakene	bipolar disorder
venlafaxine	Effexor	depression

TARDIVE DYSKINESIA

Reviewed by Henry A. Nasrallah, MD September 2003 <http://www.nami.org>

What is Tardive Dyskinesia?

Tardive Dyskinesia, or TD, is one of the muscular side effects of anti-psychotic drugs, especially the older generation like haloperidol. TD does not occur until after many months or years of taking antipsychotic drugs, unlike akathisia (restlessness), dystonia (sudden and painful muscle stiffness) and Parkinsonism (tremors and slowing down of all body muscles), which can occur within hours to days of taking an antipsychotic drug. TD is primarily characterized by random movements in the tongue, lips or jaw as well as facial grimacing, movements of arms, legs, fingers and toes, or even swaying movements of the trunk or hips. TD can be quite embarrassing to the affected patient when in public. The movements disappear during sleep. They can be mild, moderate or severe.

How does an individual get TD?

Essentially, prolonged exposure to antipsychotic treatment (which is necessary for many persons who have chronic schizophrenia) is the major reason that TD occurs in an individual. Some persons get it sooner than others. The risk factors that increase the chances of developing TD are a) duration of exposure to antipsychotics (especially the older generation), b) older age, c) post-menopausal females, d) alcoholism and substance abuse, e) mental retardation and f) experiencing a lot of EPS in the acute stage of antipsychotic therapy.

The mechanism of TD is still unknown despite extensive research. However, it is generally believed that long-term blocking of dopamine D₂ receptors (which is what all antipsychotics on the market do) causes an increase in the number of D₂ receptors in the striated region of the brain (which controls muscle coordination). This "up-regulation" of D₂ receptors may cause spontaneous and random muscle contractions or movements throughout the body, but particularly in the peri-oral and facial muscles.

How many individuals currently have TD?

It is not known how many individuals currently have TD. No large scale epidemiological prevalence survey has been done. It would also change because TD can be transient or persistent, and it can be more common in some persons with risk factors than others.

However, there have been several follow-up studies of individuals who start taking antipsychotics in order to measure the annual occurrence (incidence) of TD. Eight studies in young individuals (average age 29 years) receiving the older antipsychotics showed practically the same rate of 5% of those persons develop TD every year, year after year, until eventually almost 50-60% develop TD over their lifetime. The incidence of TD is higher in older individuals (average age 65 years) where our studies have shown that TD occurs in 26% after only one year of exposure to haloperidol, which increases to 52% after two years and up to 60% after three years.

Do the newer generation atypical antipsychotics pose a lower risk of TD?

Yes, the newer atypical antipsychotics are much safer than the older generation when it comes to TD. The first year incidence of TD with risperidone, olanzapine, quetiapine, and ziprasidone in young persons about 0.5%, which is ten-fold lower than with haloperidol. Similarly, the incidence of TD with atypical antipsychotics in the first year in geriatric patients is 2.5%, which is also ten-fold lower than with haloperidol. There is also growing evidence that the incidence is even lower in subsequent years of exposure to atypicals. The problem of TD has been significantly reduced with the advent and wide-spread use of atypical antipsychotics.

What are the symptoms of TD and is TD reversible?

As described above, the main symptoms of TD are continuous and random muscular movements in the tongue, mouth and face, but sometimes the limbs and trunks are affected as well. Rarely, the respiration muscles may be affected resulting in grunts and even breathing difficulties. Sometimes, the legs can be so severely affected that walking becomes difficult.

It must be noted that there are many other conditions that resemble TD and must be ruled out before a diagnosis of TD is made. For example, several neurodegenerative brain diseases may cause movement disorders. Very old persons may also develop mouth and facial movements with age that may be mistaken for TD. Blepharospasm is another condition that may be mistaken for TD. It should be emphasized that a history of several months or years of antipsychotic intake must be documented before TD is even considered.

TD is often mild and reversible. The percentage of patients who develop severe or irreversible TD is quite low as a proportion of those receiving long-term antipsychotic therapy.

What should you do if you notice symptoms of TD in yourself or in a family member?

Consult a psychiatrist with an established experience in using antipsychotic drugs or a neurologist who specializes in movement disorders. That physician will take a detailed history and conduct an examination and decide whether you have TD or something else, and will recommend the appropriate management.

The pattern and severity of TD is usually measured on a rating scale called "The Abnormal Involuntary Movement Scale", (AIMS for short). Psychiatrists generally assess patients receiving long-term antipsychotic medication for TD symptoms at least annually using the AIMS.

Are there effective treatments for TD?

There has never been a definitive, validated and widely accepted treatment for TD. Dozens of drugs have been tested over the past 30 years with mixed results at best. The atypical antipsychotic clozapine has been reported to reverse persistent TD after 6-12 months, possibly through gradual "down-regulation" of supersensitive dopamine D₂ receptors. Some preliminary reports suggest that other atypical antipsychotics may also help reverse TD. However, given that a large majority of persons who need antipsychotic treatment are now receiving the new atypicals and given the drastically lower incidence of TD with atypical antipsychotics, the issue of developing a treatment for TD may have become a moot one. Preventing the occurrence of TD is much more preferable to treating TD.

Abnormal Involuntary Movement Scale (AIMS)

Definition

The Abnormal Involuntary Movement Scale (AIMS) is a rating scale that was designed in the 1970s to measure involuntary movements known as tardive dyskinesia (TD). TD is a disorder that sometimes develops as a side effect of long-term treatment with neuroleptic (antipsychotic) medications.

Purpose

Tardive dyskinesia is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs, which affects 20%-30% of patients who have been treated for months or years with neuroleptic medications. Patients who are older, are heavy smokers, or have diabetes mellitus are at higher risk of developing TD. The movements of the patient's limbs and trunk are sometimes called choreathetoid, which means a dance-like movement that repeats itself and has no rhythm. The AIMS test is used not only to detect tardive dyskinesia but also to follow the severity of a patient's TD over time. It is a valuable tool for clinicians who are monitoring the effects of long-term treatment with neuroleptic medications and also for researchers studying the effects of these drugs. The AIMS test is given every three to six months to monitor the patient for the development of TD. For most patients, TD develops three months after the initiation of neuroleptic therapy; in elderly patients, however, TD can develop after as little as one month.

Precautions

The AIMS test was originally developed for administration by trained clinicians. People who are not health care professionals, however, can also be taught to administer the test by completing a training seminar.

Description

The entire test can be completed in about 10 minutes. The AIMS test has a total of twelve items rating involuntary movements of various areas of the patient's body. These items are rated on a five-point scale of severity from 0-4. The scale is rated from 0 (none), 1 (minimal), 2 (mild), 3 (moderate), 4 (severe). Two of the 12 items refer to dental care. The patient must be calm and sitting in a firm chair that doesn't have arms, and the patient cannot have anything in his or her mouth. The clinician asks the patient about the condition of his or her teeth and dentures, or if he or she is having any pain or discomfort from dentures.

The remaining 10 items refer to body movements themselves. In this section of the test, the clinician or rater asks the patient about body movements. The rater also looks at the patient in order to note any unusual movements first-hand. The patient is asked if he or she has noticed any unusual movements of the mouth, face, hands or feet. If the patient says yes, the clinician then asks if the movements annoy the patient or interfere with daily activities. Next, the patient is observed for any movements while sitting in the chair with feet flat on the floor, knees separated slightly with the hands on the knees. The patient is asked to open his or her mouth and stick out the tongue twice while the rater watches. The patient is then asked to tap his or her thumb with each finger very rapidly for 10-15 seconds, the right hand first and then the left hand. Again the rater observes the patient's face and legs for any abnormal movements.

After the face and hands have been tested, the patient is then asked to flex (bend) and extend one arm at a time. The patient is then asked to stand up so that the rater can observe the entire body for movements. Next, the patient is asked to extend both arms in front of the body with the palms facing downward. The trunk, legs and mouth are again observed for signs of TD. The patient then walks a few paces, while his or her gait and hands are observed by the rater twice.

Results

The total score on the AIMS test is not reported to the patient. A rating of 2 or higher on the AIMS scale, however, is evidence of tardive dyskinesia. If the patient has mild TD in two areas or moderate movements in one area, then he or she should be given a diagnosis of TD. The AIMS test is considered extremely reliable when it is given by experienced raters.

If the patient's score on the AIMS test suggests the diagnosis of TD, the clinician must consider whether the patient still needs to be on an antipsychotic medication. This question should be discussed with the patient and his or her family. If the patient requires ongoing treatment with antipsychotic drugs, the dose can often be lowered. A lower dosage should result in a lower level of TD symptoms. Another option is to place the patient on a trial dosage of clozapine (Clozaril), a newer antipsychotic medication that has fewer side effects than the older neuroleptics.

Examination Procedure

Either before or after completing the examination procedure, observe the patient unobtrusively at rest (e.g., in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms. Have the person remove their shoes and socks.

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the *current* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient *now*.
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they *currently* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.) [±activated]
9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.) [activated]
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice. [activated]

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
Institute of Mental Health

NAME: _____
DATE: _____ National
Prescribing Physician _____

INSTRUCTIONS:

Complete Examination procedure
Before making ratings

CODE 0=None
1=Minimal, may be extreme normal
2=Mild
3=Moderate
4=Severe

MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.		RATER	RATER	RATER	RATER
		Date	Date	Date	Date
Facial and Oral Movements	1. Muscles of Facial Expression e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. Lips and Perioral Area e.g., puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. Jaw e.g. biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Extremity Movements	5. Upper (arms, wrists,, hands, fingers) Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Trunk Movements	7. Neck, shoulders, hips e.g., rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Global Judgments	8. Severity of abnormal movements overall	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. Patient's awareness of abnormal movements Rate only patient's report No awareness 0 Aware, no distress 1 Aware, mild distress 2 Aware, moderate distress 3 Aware, severe distress 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Dental Status	11. Current problems with teeth and/or dentures?	No Yes	No Yes	No Yes	No Yes
	12. Are dentures usually worn?	No Yes	No Yes	No Yes	No Yes
	13. Edentia?	No Yes	No Yes	No Yes	No Yes
	14. Do movements disappear in sleep?	No Yes	No Yes	No Yes	No Yes

Diagnostic Procedure: The Tuberculin Test Follow-up of Tuberculin Test Reactions

- POLICY:** Results of tuberculin skin test reactions will be followed as outlined in the Procedure section below.
- PURPOSE:** To ensure appropriate follow-up on all persons who have had tuberculin skin tests.
- PROCEDURE:** Follow-up medical evaluation, including chest x-rays, is imperative for all persons with a skin test reading classified as positive. Additional tuberculin skin testing and/or anergy testing may be appropriate for persons with a skin test reading classified as negative (see Chapter 6 of *Core Curriculum*).

For persons with a skin test reading classified as **positive** (see Section 4.0):

- A chest x-ray as soon as possible.
- A complete medical evaluation, including symptoms of tuberculosis, prior medical history, family history.
- Bacteriologic examinations of sputum or other body fluids for the presence of *M. tuberculosis* (if indicated because of abnormal chest x-ray or symptoms of possible TB disease).
- If current tuberculosis disease has been ruled out by the above procedures and there is no history of prior treatment for either tuberculosis disease or infection, consideration of infection treatment to prevent progression of tuberculosis infection to disease (see Chapter 6 of *Core Curriculum*).
- Provided that there is documentation of a tuberculin skin test classified as positive and that there has been a chest x-ray interpreted as negative following that tuberculin skin test, there is no need for further tuberculin testing. Similarly, there is no need for additional chest x-rays unless the person develops symptoms compatible with pulmonary tuberculosis.



MONITORING

Agency Documentation Review
MRDD Medicaid Wavier

Required Documentation	Compliance/Notes
One externally conducted fire inspection per year (Res Hab and On-site Day Hab)-State Fire Marshal	
Annual water inspection (if not on public water supply)	
Documentation of regular and preventive maintenance performed on agency-owned vehicles , agency-owned equipment and agency-owned buildings .	
Insurance verification for agency-owned vehicles (must be in vehicles).	
Emergency information & phone numbers maintained and accessible to person and staff at all times.	
Emergency drills (on all shifts on which individuals supported are present): <ul style="list-style-type: none"> • Day Hab: 1 fire per month. 2 disaster drills per year • GH 4-9 people: 1 fire and 1 disaster drill quarterly with a minimum of 1 of each during sleep hours. Must also conduct fire drill within 1 week of new consumer • GH 10+ people: 1 fire and 1 disaster per month. At least 2 annually during sleep 	
Fire extinguisher expiration date or preventative maintenance tag/documentation, and indicator of charge. Extinguisher has directions for use on the equipment.	
Community Event Reports	
Documentation of repairs and ongoing preventative maintenance for individuals'	

**Consumer Record Review
MRDD Medicaid Waiver**

Core Evidence	Name	Name
Emergency Contact Info & Other Pertinent Info		
Rights Reviewed & Training - If rights limited, signed document indicating involvement of individual & info about possible external advocates		
If have guardian or need guardian, limitations of rights explained		
Current Authorized Personal Plan - legal signature dated before treatment begins		
Restrictions of Rights/Plan to Restore		
Limitations of Freedom of Movement		
Self-Administration of Meds		
All Supports Identified (staff, adaptive equipment, etc.)		
Ability to regulate water temperature		
Ability to handle toxic chemicals		
Identification of Special Needs (special diets, exercise program, etc.)		
Annual Physical Exam (for females, include pelvic)		
Annual Dental Exam		
Hepatitis B Screening or Immunization		
TB Test		
Immunization Records Present		
Current Physician Orders		
Lab Work (what, when, results)		
Info about medications documented (type, purpose, time, side effects, instructions, duration)		
Current physician orders (frequency of physician signature may vary by physician and/or policy)		
Record of prescribed medications to indicate administration		
Medications' effectiveness evaluated at least annually (or more often if indicated)		

**Personnel Record Review
MRDD Medicaid Waiver**

Core Evidence/Components	Name	Name	Name	Name
Hire Date				
Emergency Procedure Training				
Level I Med Aide or approved med training (note expiration date) - every two years				
CMT/RN/LPN (note license expiration)				
CPR Training (note expiration date) {RC = 1 year; AHA = 2 years}				
Standard First Aid Training (note expiration date)				
Confidentiality Training				
MANDT or CPI Training				
Client Rights Training				
Blood Borne Pathogens Training				
Criminal Background Check (e.g., FCSR, Highway Patrol, H&SS—EDL, DFS, DMH) - initiated on date of hire				
Training on prevention, detection, & reporting of abuse/neglect - every two years				
Annual review of confidentiality policy (formal training if per P/P)				
Training on use/maintenance of equipment/devices (if used by individuals supported)				
Current Driver's License				
Proof of Current Auto Insurance				
Vehicle Safety Inspection				

Policy & Procedure Review

MRDD Medicaid Wavier

Policy	Compliance/Notes
Policy regarding Due Process when there are limitations of rights of individuals supported <ul style="list-style-type: none"> Policy identifies external advocacy contacts for individuals Policy includes person's right to appeal and the appeal process 	
Written policy clearly stating that abuse/neglect is prohibited. New definitions included.	
Written policy that clearly states any research must comply with states and federal regulations.	
Policy regarding confidentiality of information. Policy is reviewed with staff annually and review is documented)	
Policy on criminal background checks . Initiated before contact with consumer. Has new wording regarding FCSR and DMH background check (from March 04 CSR) <ul style="list-style-type: none"> Procedures for obtaining review Procedures for confidentiality of records Guidelines for evaluating information received regarding exclusionary crimes 	
Infection and control policies that are in accordance with current CDC and DHSS recommendations. (At a minimum, should address body substances precautions and reporting of communicable diseases).	
Written procedures for meeting emergencies and disasters such as fire, severe weather, missing person, vehicle breakdown, etc. available to all staff. (Copies of written procedures should be in each home for staff to review/use- may not be in p/p manual).	
Procedures on notifying the regional center of any injuries or unusual incidents .	

MISSOURI DEPARTMENT OF MENTAL HEALTH
MRDD MEDICAID WAIVER PROGRAM
CERTIFICATION

The Missouri Department of Mental Health, Division of Mental Retardation and Developmental Disabilities developed value-centered, outcome-based certification principles for services provided through the Home and Community Based Waiver. The Certification Principles are outlined in four basic chapters: community membership, self-determination, rights, and meeting basic needs. Survey team members have embraced these principles and when coming to meet the consumer and providers of services, an instrument was prepared for ready reference to look at basic rights and meeting basic needs. The intent of this instrument was for clarity and consistency. Providers have a copy of this instrument and can use it throughout the years to assure that all criteria are being met to protect the health and safety of the consumer. This is the tool that surveyors will be using when they complete their visits for certification every two years.

The SURVEY INSTRUMENT can be found at the following website:
www.dmh.missouri.gov/cmrc/Documentation/surveyinstr.pdf

Who to Contact in Employment and Community Services

(Please use e-mail to facilitate response)

Requests for presentations, benefits and recognition of CARF accreditation, and interpretation of standards:

Paul Andrew, Managing Director (ext. 112); pandrew@carf.org

Requests for information on Employment and Community Services marketing and promotional efforts:

Reneé Bibby, Coordinator of Marketing and Research. (ext. 133); rbibby@carf.org

- CUSTOMER SUPPORT-

For information on applying for a survey; interpretation of standards; survey reports; Quality Improvement Plans; general survey or program information, please contact the Resource Specialist for your region. Please see the map on the back of this flyer to determine in which region your organization is located.

Julia Vining, Resource Specialist, Region 1 and Canada (ext. 170); jvining@carf.org

Scott Brandt, Resource Specialist, Region 2 (ext. 252); sbrandt@carf.org

Mary K. Boegemann, Resource Specialist, Region 3 (ext.142); mboegemann@carf.org

Position Open, Resource Specialist, Region 4, for questions contact Angela Ruffalo, ext. 131

Inquiries from state/provincial and federal funders, requests for appeals, interpretation of standards; policies and procedures of site visits, to report allegations:

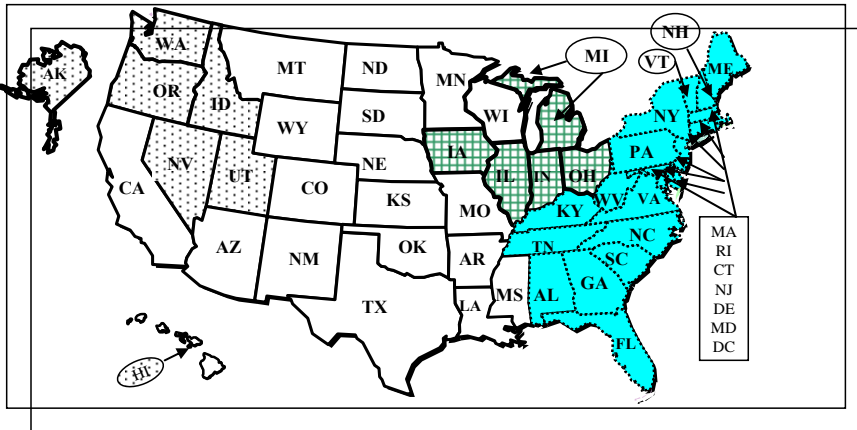
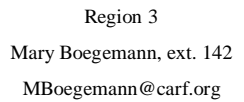
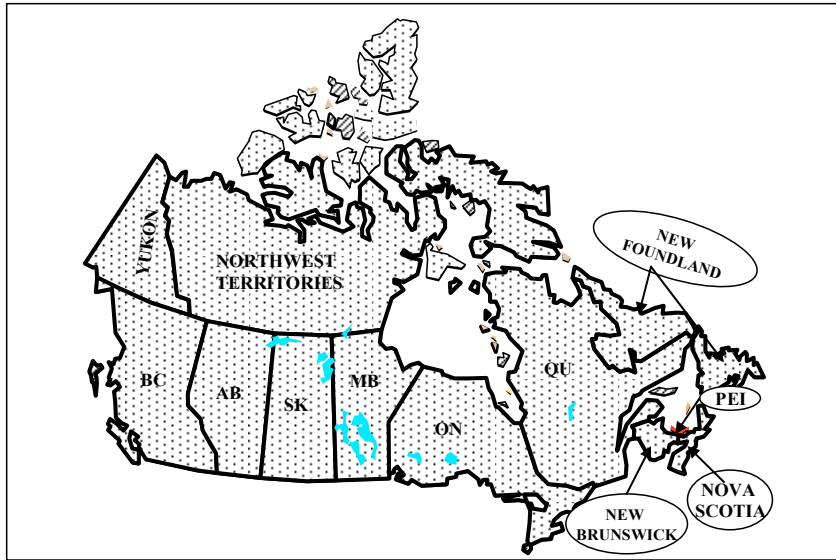
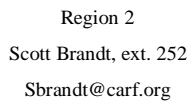
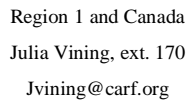
Margaret McHenry, Account Manager (ext. 106); mmchenry@carf.org

Requests for information regarding scheduling ECS surveys, specific dates for the site survey, or problem dates (after CARF has received the Intent to Survey):

Linda Matola, Scheduling Coordinator (ext. 156); lmatoala@carf.org

Requests for information regarding field reviews or National Advisory Committees, information packets, to report informational changes, including e-mail address, and organizational name or address changes, or to request information on CARF accredited providers in a specific state:

Angela Ruffalo, Account Services Coordinator (ext. 131); aruffalo@carf.org



CARF - The Commission on Accreditation of Rehabilitation Facilities, Inc.



PERSON CENTERED PLAN

DMRDD Person Centered Planning Process

Each individual who receives DMRDD services funded through the division will have a Person Centered Plan (PCP) in place. The PCP is the authorizing document that drives **all** services specific to the individual and must be updated at least every 365 calendar days. The PCP can be amended anytime during the calendar year.

The PCP contains information and outcomes vital to the overall well-being and chosen outcomes of the individual to include but not limited to health/safety issues, daily activities, relationships, communication and finances. A copy of the current PCP should be maintained in the individual's record at their residence. It is important for the Community RN to be familiar with the content of the PCP. The Community RN's role in the Person Centered Planning Process will vary based on the amount of nursing supports needed by the individual.

Each individual has a treatment planning team consisting of the individual, guardian, family members, friends, provider agency staff and service coordinator. Other advocates who may be involved in this process may include the Regional Center Quality Management RN, Community RN, therapist, physicians etc...

Each individual has a PCP planning meeting prior to the PCP implementation date, the Community RN as well as other advocates may participate in the planning process through written report and/or attendance. The Community RN is not required to attend all PCP meetings however any pertinent medical/health information and outcomes should be included in the current PCP.

The progress towards the PCP outcomes are monitored through the service coordinator's monthly review process. This process will include a review of the Community RN's Monthly Health Summary which would have been submitted to the agency QMRP for attachment to their monthly summary.

Prior to the PCP planning date a Health Inventory will be completed by designated Regional Center staff. The Health Inventory is a statewide tool which identifies health issues through a series of indicators which are scored based on level of acuity. Those individuals meeting a score threshold of 30 or above will receive a Nursing Review completed by the Regional Center Quality Management RN. Information from the review will be provided to the PCP planning team for utilization in the PCP planning process. This quality assurance function (Health Inventory and Nursing Review) is referred to as the Health Identification and Planning System (HIPS).

Individual Plan Preparation Tool

Please return the completed form to the assigned Casemanager at least 2 weeks prior to the scheduled meeting. Thank you for taking time to assist us in our effort to make this Individual Plan as complete as possible.

1. Describe_____:

A. List personality traits: (Examples are: friendly, likes to be around people, quiet, out-going, etc.)

B. List abilities and accomplishments: (Examples are: has learned to cook..., obtained a job at..., is great housekeeper, etc.)

C. List individual/family/social roles: (Examples are: voter, brother, volunteer, Church member, bowler, etc.).

2. How does the person communicate needs/wants? What supports are needed in this area? (Examples are: uses alpha talker to..., uses pictures to choose..., etc.).

3. Who are the important people in the person's life and what role do they play? (Examples are: parents visit and call several times monthly, pastor visits 1 time per month, etc.).

4. What are the person's likes/preferences/interests and things they enjoy? (Examples are: swim, prefers soda over other drinks, enjoys attending plays, etc.).

5. List dislikes pet-peeves, non-negotiable, and things that may upset or bother the person. (Examples are: dislikes being told what to do, pet-peeves are persons getting in their space, non-negotiable is, must have cigarettes available to them, etc.).

6. What do you think are the person's dreams and goals both short-term and long term?

7. What specific supports does your agency provide to the individual to ensure he/she is successful? (Examples are: personal care, transportation, medications, etc.).

8. List all medical issues and concerns:

A. Current medication, dosage and reason for (Attach additional information if needed).

B. General physician, psychiatrist, dentist, optometrist, and any other specialist (name and town).

C. Any known allergies.

D. Special medical needs/supports including dietary, adaptive equipment, modifications, etc.

9. List any behavioral challenges/concerns and how your agency supports or assists the person with these challenges:

10. List other agencies, organizations, natural supports (family, friends, etc.) that are involved in the person's life and how they are involved:

11. Suggested Outcomes and Action Steps for new Personal Plan:

Outcome A:

Action Step 1:

Action Step 2:

Outcome B:

Action Step 1:

Action Step 2:

Outcome C:

Action Step 1:

Action Step 2:



QMRP

PERSONNEL

Required Training

The required trainings for staff (per certification and the contract) are:

Training	Guidelines
Emergency Procedure Training i.e. Disaster Plan: Fire, Tornado, etc	Annually
Level I Med Aid or approved med training Exempt from Training: CMT/RN/LPN (note license expiration date)	Every 2 years, 1 st day of training within 90 days of employment: Staff cannot pass mediations without training.
CPR	American Red Cross- 1 year; American Heart Association-2 years: Staff without training cannot work alone with consumer
First Aid	Every 3 years without training can not work alone with consumer
Confidentiality (actually only have to read/sign their agency's policy)	Annually
CPI or MANDT (If you have a restraint policy)	one day training within 90 days of employment; recertification annually
Client Rights Training	Annually
Blood Borne Pathogens Body Substance Precautions	Annually
Training on prevention, detection, and reporting of abuse/neglect	Every 2 years
Community Event Reporting	This is a training that is completed during the Basic Provider Training. Additional training can be obtained by the Quality Support Person and the Casemanager.

Addition Trainings may be required based on consumer needs.

- Emergency procedures for the home/facility i.e. Behavior Support Plan and/or Crisis Plan
- Training for cleaning/maintain adaptive equipment if someone they support requires adaptive equipment.
- Training on special diets.

Additional Trainings that the Central Missouri Regional Center offers:

- Positive Behavior Support
- Person Centered Planning
- Documentation
- Relationships are for Everyone!
- Community Event Reporting (CER) Training

Other Agencies that provide additional Training:

- Missouri Parents ACT
- Alzheimer's Association
- Judevine

Job Functions for the Community RN Position

I. Monitor the health and safety of the individuals receiving residential services.

The Community RN will be responsible for:

- completing a monthly face to face assessment of the individual consumer and record any findings.
- reviewing the individual consumer record monthly to include physician orders and the medication administration record.
- maintaining communication with agency management and habilitation teams including reporting and documenting of all changes in the individual's health status, needs, and identified deficiencies in the standard of care provided to consumers.

II. Provide appropriate delegation and supervision of Unlicensed Assistive Personnel (UAP) or Licensed Practical Nurse (LPN) who perform such duties as medication administration and other nursing tasks when applicable, and document those activities. (Nursing Practices Act Chapter 335 RSMo.)

The Community RN will be responsible for:

- identifying needs for staff supervision /delegation or specialized instruction and any follow-up or plan of action that may result.
- oversight of all functions of medication administration by medication aides certified through DHSS or DMRDD, to include but not limited to the review of physician orders, medication administration record and staff documentation. This would also include periodic inspection of technique and skill of certified aides delegated to pass medications.
- identifying nursing supports individualized to specific consumer needs.
- identifying the support staff who are competent to receive specialized instruction and delegation to perform specific tasks.
- ensuring that specialized instruction regarding identified tasks is provided and documented on the designated form.
- ensuring through periodic oversight/supervision that the identified staff are able to perform the specific task as delegated.

III. Accountability for Activities

The Community RN will be responsible to:

- account for their time dedicated to the functions of the Community RN Program each month. This will be accomplished by completion of the Monthly Service Log.
- ensure the total hours available for each month are accounted for and do not carry over to the next month.
- ensure the Monthly Service Log is completed accurately each month and submitted to their employer for review and maintenance of the document.

Month	Year
-------	------

Community RN: _____ RN Contact Phone # _____

- ☐ **Assessment:** Face to face evaluation with consumer and staff in their home to include assessment of consumer's specific issues.
- ☐ **Labs:** Review, analyze and interpret lab results. Ensure that the agency has a protocol established for necessary labs and follow-up
- ☐ **Review of Physician Orders:** The monthly review of physician's orders for physician signature, accuracy and staff compliance. To include the signature/date of the Community RN identifying the review of any new orders.
- ☐ **Review of Medication(s)** To include monthly review of the medication administration record (MAR) for accuracy (compare to orders) and staff compliance, medication labels, monitor for side effects (including Tardive Dyskinesia), effectiveness, frequency of PRN use, drug storage of routine and PRN medications, and check for supporting diagnosis.
- ☐ **Review of Records:** To include weight, immunization records, bowel, vitals, blood sugar, dietary, fluids, seizure, menses, skin, range of motion, consultation reports, event reports for falls, injuries, prn psychotropic meds and medication errors, hospitalization and ER reports, and significant change in behavior etc.

* Initial and date all documents reviewed in the agency.

- ☐ **Delegated Nursing Tasks/Specialized Instruction/Supervision:** Which include but are not limited to those tasks listed in the MRDD Health Reference Manual and/or specialized instruction and supervision of tasks based on the individualized needs of the consumer (*does **not** include med administration, CPR and first aid courses*).
- ☐ **Other:** Any additional services not specified on this form i.e. Direct nursing care, nursing directives pertinent to health monitoring processes (current and previous month) etc.

[illegible]

(When applicable clarify teaching provided and list recipient(s) by name)

[illegible][illegible]

Name & Title	Date	Name & Title	Date
Name & Title	Date	Name & Title	Date
Community RN Signature		Date	

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Missouri Department of Mental Health
Division of Mental Retardation and Developmental Disabilities

Community RN Monthly Service Log Operation Instructions

Purpose: The RN Service Log will serve as an auditing tool for both the Provider Agency and MRDD to account for the Community RN services and monthly hours.

Process:

- The Community RN will be responsible to account for their time dedicated to the functions of the Community RN Program each month. This will be accomplished by the completion of the service.
- The Community RN will need to sign and date the service log monthly.
- Total hours should be fulfilled each month and not carried over.
- The Community RN will be responsible for ensuring that the form is completed accurately each month and submitted to their employer for review and maintenance of the document.

Directions:

1. **Provider Agency Name:** Name of the company which is providing the contracted Community RN service.
2. **Month/Year:** The month and year service is provided.
3. **Total Authorized Hours Per Month:** The formula used to establish a rate per contract was 1.25 hours per person however, to accommodate flexibility based on individual needs, as long as the Community RN provides at minimum a monthly evaluation of each individual and oversight of delegated tasks, the hours may be distributed based on individual needs within the provider agency. The hours **cannot** carry over from one month to the next. The RN needs to circle if the total number of hours listed are per agency or based on 1 Community RN's hours for providing service for that agency.
4. **Date:** Current date of service to include month and day.
5. **Individual Name:** Full name of the individual who is receiving the Community RN service.
6. **Facility Name:** Name of the individual's specific residence.
- 7-16 choose all that apply**
7. **Assessment:** Face to face evaluation with the individual and staff in the home including assessment of individual's specific issues.
8. **Labs:** Review, analyze and interpret lab results. Ensure that the agency has a protocol established for necessary labs and follow-up.
9. **Review of Physician Orders:** The monthly review of physician's orders for physician signature, accuracy and staff compliance. To include the signature/date of the Community RN identifying the review of any new orders.
10. **Review of Medication(s):** To include monthly review of the medication administration record (MAR) for accuracy (compare to orders) and staff compliance, medication labels, monitor for side effects (including Tardive Dyskinesia), effectiveness, frequency of PRN use, drug storage of routine and PRN medications, and check for supporting diagnosis.
11. **Review of Records:** To include wt, immunization records, bowel, vitals, blood sugar, dietary, fluids, seizure, menses, skin, range of motion, consultation reports, event reports for falls, injuries, psychotropic meds and medication errors, hospitalization, ER reports and significant change in behavior etc.
12. **Delegated Nursing Tasks/Specialized Instruction/Supervision:** Which include but are not limited to those tasks listed in the MRDD Health Reference Manual and /or specialized instruction and supervision of tasks based on the individualized needs of the individual (*does not include med administration, CPR and first aid courses*).
13. **Other:** Any additional services not specified on this form i.e. direct nursing care, nursing directives pertinent to health monitoring processes etc.
14. **Total Number of Hours for Date:** Total amount of time provided for Group Home, Residential

Care Facility or ISL for that date.

15. **Total Time Per Month:** Total amount of time provided for all services for the month.
16. **Community RN Signature:** Full signature of the Community RN providing the logged service.
17. **Community RN Name Printed:** Printed name of Community RN providing the logged service.
18. **Date:** Date of RN signature.

Community RN Delegation Of Specified Nursing Task

Individual's Name: _____ ID Number: _____

Provider Agency Name: _____ Facility Name: _____

Delegated Task: _____

Purpose of Task: _____

The following agency employees have been trained by a licensed person, demonstrate competency in all instructed procedures and are being delegated the task indicated above. This delegation and individualized instruction is specific to this individual and may not be transferred to other individuals with similar needs within this or other agencies.

Name/Title	Staff Signature
1. _____ Initials	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____
<input type="checkbox"/> Rescinded Date_____

The delegating RN is responsible for the provision of guidance and ongoing evaluation for the delegated nursing task including periodic inspection based at intervals determined by the delegating RN. The delegating RN maintains authority to require corrective action or rescind delegation of this task.

Task Rescinded: ☐ Change in Health Status ☐ Other_____

Delegating RN: _____ Date: _____
Signature & Title

SPECIALIZED INSTRUCTION FOR DELEGATION

PROCEDURES/Steps to follow to perform the task	What to OBSERVE for and REPORT, What to DO, and WHOM to CONTACT.

***Attach any additional instructional documentation**
Instructional Licensed Medical Professional:

Signature and Title Contact # Date

Delegating RN if different than Instructing Medical Professional:

Signature and Title

QMRP LOG

Group Home _____ ISL _____

Provider Agency Name: _____ Month/Year_____ Total Authorized
Hours/Month_____

[illegible]

Total Hours per week: Week 1 _____ Week 2 _____ Week 3 _____ Week 4 _____

*Signature*_____

Staffing Pattern Ratio's

A typical ISL staffing pattern will be 1-3 ratio. The individual planning team may request additional staffing for circumstances where the consumers have severe behavioral problems, extraordinary medical needs, additional community supports needs or other things. Staffing patterns must reflect all staff and when the supports are provided to the consumer(s) to match the number of hours on the ISL budget.

Group Homes have different staffing ratios based on the level of care needed by the individuals living in the home. The expectation is that the ratio will be in accordance with the level of care. Refer to "Staffing Patterns" section of this manual in the Financial Chapter.

Staffing patterns will be monitored by the service coordinator during monthly visits.

Medicaid Home & Community Based Waiver
Staffing Pattern Schedule

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:00 a.m.							
8:00 a.m.							
9:00 a.m.							
10:00 a.m.							
11:00 a.m.							
12:00 p.m.							
1:00 p.m.							
2:00 p.m.							
3:00 p.m.							
4:00 p.m.							
5:00 p.m.							
6:00 p.m.							
7:00 p.m.							
8:00 p.m.							
9:00 p.m.							
10:00 p.m.							
11:00 p.m.							
12:00 a.m.							
1:00 a.m.							
2:00 a.m.							
3:00 a.m.							
4:00 a.m.							
5:00 a.m.							

Code	Job Title	Hours/week	Required Hourly Compensation

Scheduled Exceptions



QMRP

SAFETY



Consumer: _____ **Month:** _____

Month: _____

[illegible]

Mechanical supports and adaptive equipment have a physician order with documented preventative maintenance and repair. Applicable staff training is completed and documented. Environments are modified to ensure safety. (Refer 4.2.24 and 4.2.03)

PERSONAL SAFETY ASSESSMENT TOOL

Consumer name: _____ Date of Assessment _____

Staff Signature _____

1. Self-Care category: consumer is able to	Yes	No	Comments
Bathe self and complete personal hygiene			
Dress self appropriate to weather			
Feed self, including cutting foods and opening cartons			
Dial 911 in the event of an emergency			
2. Language Skills category: consumer is able to			
Comprehend the spoken word			
Communicate response and requests			
Notify someone if there was no staff available			
Read a book, magazine, or newspaper			
Write a letter or note			
3. Language Skills category: consumer is able to			
Understand the content of television, radio, or movie			
Identify common domestic products and state the use			
State the value of money-pennies/nickels/dimes etc.			
Look at the clock and tell the time, AM or PM			
State their name, address, and phone number			
4. Mobility Skills category: consumer is able to			
Make transfers independently			
Move about their environment safely			
Operate safely household equipment, such as television, radio, vacuum cleaner, assistive devices			
Cross the street safely			
Use a key to lock and unlock the door to their home			
5. Self-Direction category: consumer is able to			
Make personal decisions about their schedule of activities			
Make independent major life decisions			
Maintain interpersonal relationships			
Make independent choices about eating			
Make financial decisions and keep track of obligations			
6. Level of Independence category: consumer is able to			
Carry out routine chores safely without reminders			
Independently select and participate in a community activity on a regular basis			
Be left alone for 24 hours without being considered at risk ✓			
Talk about the importance of being prompt for work or school			
State several approaches for finding a job			
Talk about his/her disability			

Personal Safety Assessment Tool Instruction Sheet
Adapted from Missouri Critical Adaptive Behaviors Inventory

The intent of this tool is to assure that an adequate assessment is being completed in determining what level of independence can be granted for the individual in community placement.

Read through each category, check off yes or no as it applies to the individual in community placement. The comment section is to be used to identify what supports are needed by the individual to allow that level of independence.

When a personal safety risk is identified through the use of this assessment tool, an addendum to the personal plan will be written. Goals and objectives will be made by the provider with regards to the abilities and support needs of the consumer. Ongoing monitoring of the safety risks will be documented to assure that the protection and supports for the consumer safety needs are provided. The provider will train staff on each of the consumer's personal safety issues. Documentation of the training will be in the staff training file. There will be ongoing monitoring of the progress of the consumer

Environmental Monitoring Guidelines

ISL/Group Home: _____ Date: _____

Guidelines:	YES	NO
1. Soap, towels, and disinfectants are available in the kitchens and bathrooms.		
2. Staffing patterns are documented and available for monitoring.		
3. Consumer living areas are maintained to ensure their safety.		
4. Water temperature is maintained at a safe level.		
5. Needed home modifications for consumer health and safety are completed.		
6. Waivered group homes and day hab sites are required to have an annual inspection by the State Fire Marshall with documentation on site. ISL's are required to get a local fire inspection with documentation on site.		
7. The temperature of a consumer's residence or program area is within 68-78 degrees.		
8. Emergency drills must be completed quarterly in residential sites (1 fire and 1 natural disaster) at various times of the day. One of these drills must be conducted during the night shift. There must be documentation available on date and time of drill, type of drill, time taken to evacuate to meeting place, problems encountered during the evacuation, and number of consumers present. If adaptive equipment is needed to respond to drills, there must be documentation of availability. Group homes must conduct a drill within one week after the arrival of a new resident.		
9. Waivered day programs will complete a fire drill monthly and two natural disaster drills yearly with required documentation completed.		
10. Consumer environments must have at least two exits or pathway on each floor that is accessible.		
11. Consumer homes have at least one fire extinguisher that is charged with a current inspection tag.		
12. Consumer homes must have an operational smoke detector in or near each bedroom and at least one detector per floor. Alarms must be adapted to meet the special needs of consumers.		

Environmental Monitoring Guidelines

ISL/Group Home: _____ Date: _____

Guidelines:	YES	NO
13. First aid supplies are accessible and not expired (bandages, band-aids, antiseptic, tape for bandages, and scissors).		
14. Consumer emergency information is accessible to staff.		
15. Combustible supplies and toxic substances must be stored safely. Toxic materials must be locked if so stated in the IP document for consumer safety. Toxic substances should be locked in group home and day program environments.		
16. QMRP hours are logged and consistent with habilitative guidelines.		
17. Nursing reviews completed by the Community Nurse are present in the consumer's file.		
18. The criteria for safe medication storage are outlined in IP's for consumers residing in ISL's. These guidelines are followed by the agency.		
19. Medications are locked at day programs and group homes with Class II narcotics double locked. Topicals and oral medications are stored separately.		
20. Medication is disposed of in accordance with Level I Med Aide and MRDD Med Aide curriculum guidelines. This requires a disposal log or notation on the back of the MAR. Disposal of a contaminated medication must be witnessed by two people, one of which needs to be Level I Med Aide trained.		
21. Facilities are free from unusual odors and are clean.		
22. Emergency numbers are readily available and staff can easily locate them.		
23. Adaptive equipment if applicable is provided for the consumer documented in the IP with doctor's orders available in consumer file		
24. There is a hazard free means to dispose of sharp objects, needles, etc.		

VEHICLE CONDITION SHEET

Vehicle: _____ Date: _____ Group Homes/ISL: _____

TIRES- CHECK FOR WEAR AND TIRES ARE AIRED UP	CHECK HEAD LIGHTS	
CHECK FOR ANY OUTSIDE DAMAGE	CHECK MIRRORS	
CHECK FOR OVER ALL CLEANILINESS OF VEHICLE INSIDE AND OUT	CHECK HORN	
REPORT ANY TRASH OR MESS IN THE CAR	CHECK SIGNALS	
CHECK BRAKES	CHECK EMERGENCY EQUIPMENT	
CHECK PARKING BRAKE	REPORT ON ANY PROBLEMS WITH THE VEHICLE	
CHECK BRAKE LIGHT	CHECK OIL CHANGE STICKERS/IF DUE REPORT ON NOTE	
CHECK WIPERS	REPORT ANYTHING YOU THINK IS IMPORTANT	
CHECK WASHIER FLUID FILLED	IS TANK FILLED WITH GAS (AT LEAST $\frac{1}{2}$)	
EXPLAIN IN DETAIL ANY DEFECTS CHECKED OR FOUND		
I HAVE INSPECTED THE ABOVE UNIT AND REPORTD ALL DEFECTS KNOW TO ME.	DRIVER'S SIGNATURE	Date::
I HAVE CHECK ALL NEEDED REPAIRS OF THE DEFECTS REPORTED ON THIS UNIT.	SIGNATURE OF TRANSPORTATION SUPERVISOR	Date:

Vehicle Safety Check

Guidelines:	YES	NO
1. Routine preventive maintenance of vehicles and equipment is completed with documentation available.		
2. All staff transporting consumers will have a valid copy of their driver's license in their personnel file. When a private vehicle is being used, current verification of auto insurance will also be found in the personnel file.		
3. All facility vehicles must be properly insured, licensed, and inspected with documentation available. Private vehicles transporting consumers must also be licensed and inspected.		
4. Vehicles transporting consumers must have operational seat belts.		
5. Consumer emergency information (diagnoses, medications taken, and drug allergies which would impact emergency medical treatment; 911 and other emergency contact numbers, Medicaid number) and a first aid kit must be present whenever a consumer is being transported.		

Signature_____

Date _____

Signature_____

Date _____

Signature_____

Date _____

Signature_____

Date _____

Signature_____

Date _____

Signature_____

Date _____

Signature_____

Date _____